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IN THE

Supreme Court of the United States

JOHN DOE and RICHARD SMITH,

Petitioners,

—v.—

MUTUAL OF OMAHA INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Does Title III of the Americans with Disabilities Act, which forbids discrimination in the full and equal enjoyment of the goods and services of public accommodations, prohibit an insurer from denying only policyholders with HIV or AIDS full use of a general coverage limit, even for identical treatments it otherwise covers, where the insurer concedes that the safe harbor for risk-based insurance distinctions in Section 501(c) does not apply?

2. Does the McCarran Ferguson Act's limit on unintentional federal interference with state insurance regulation allow federal courts to apply the Americans with Disabilities Act, which specifically relates to the business of insurance, to a discriminatory practice that the insurer concedes does not comply with state law?

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John Doe and Richard Smith respectfully petition for a writ of *certiorari* to review the judgment of the United States Court of Appeals for the Seventh Circuit.

OPINIONS BELOW

The Court of Appeals' decision is reported at 179 F.3d 557 (7th Cir. 1999) and reprinted at Appendix ("App.") 1a (majority); 15a (dissent). The Order denying rehearing and rehearing *en banc* is reprinted at App. 80a. The District Court's final judgment is reprinted at App. 18a; that ruling incorporates the District Court's ruling on Respondent's motion to dismiss, which is reported at 999 F. Supp. 1188 (N.D. Ill. 1998) and reprinted at App. 59a.

JURISDICTION

The judgment sought to be reviewed was entered June 2, 1999. App. 1a. On August 3, 1999, the Court of Appeals denied Doe and Smith's timely petition for rehearing and rehearing *en banc*. App. 80a. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

This case involves Titles III and V of the Americans with Disabilities Act, 42 U.S.C. §§ 12181-12189, 12201, and 12206 (1995) ("ADA" or "the Act"), and Department of Justice regulations, 28 C.F.R. § 36.212 (1998), and technical assistance, Title III Technical Assistance Manual § III-3.11000 (1993). It also involves the McCarran-Ferguson Act, 15 U.S.C. § 1012(b) (1997) ("MFA"). Relevant sections are reprinted at App. 81a to 93a, with selected portions reprinted below.

Section 302(a) of Title III of the ADA provides:

§ 12182. Prohibition of discrimination by public accommodations

(a) General rule

No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.

Section 302(b) of Title III of the ADA provides:

(b) Construction

(1) General prohibition

(A) Activities

(i) Denial of participation

It shall be discriminatory to subject an individual or class of individuals on the basis of a disability or disabilities of such individual or class, directly, or through contractual, licensing, or other arrangements, to a denial of the opportunity of the individual or class to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations of an entity.

(ii) Participation in unequal benefit

It shall be discriminatory to afford an individual or class of individuals, on the basis of a disability or disabilities of such individual or class, directly, or through

contractual, licensing, or other arrangements with the opportunity to participate in or benefit from a good, service, facility, privilege, advantage, or accommodation that is not equal to that afforded to other individuals.

* * *

(2) Specific prohibitions

(A) Discrimination

For purposes of subsection (a), discrimination includes —

(i) the imposition or application of eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any goods, services, facilities privileges, advantages, or accommodations, unless such criteria can be shown to be necessary for the provision of the goods, services, facilities, privileges, advantages, or accommodations being offered;

* * *

Section 501(c) of Title V of the ADA provides:

§ 12201. Construction

* * *

(c) Insurance

Titles I through IV of this Act shall not be construed

to prohibit or restrict —

> (1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or
>
> (2) a person or organization covered by this Act from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law;
>
> * * *
>
> Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of Title I and III [42 U.S.C. §§ 12111 et seq., and 12181 et seq.].

Section 2(b) of the McCarran-Ferguson Act provides:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance.

STATEMENT OF THE CASE

The issue in this case is whether Title III of the ADA prohibits an insurance company from arbitrarily denying policyholders disabled by HIV or AIDS full coverage for medical needs that the company otherwise provides to persons without disabilities. Petitioners John Doe and Richard Smith[1] are infected with HIV and have health insurance policies with Respondent Mutual of Omaha Insurance Company ("Mutual"). Mutual provides coverage of $1 million or more to policyholders for their medical needs but refuses to provide this same amount for medical needs related to HIV or AIDS; coverage for these disabilities is capped at a lifetime maximum of either $25,000 or $100,000 (hereinafter "AIDS caps"). As Mutual stipulated, the practical consequence of its AIDS caps is that coverage for even identical treatments that are covered for everyone else is denied solely because of disability. Mutual admits that its AIDS caps have no actuarial basis, that they are not consistent with state law, and that Section 501(c) of the Act — the safe-harbor provision that allows certain risk-based coverage distinctions that are "based on or not inconsistent with State law" — does not apply. Accordingly, Mutual's AIDS caps are wholly arbitrary and plaintiffs assert that, under Title III, they are entitled to "full and equal enjoyment" of the general coverage limit in their policies that policyholders without disabilities already enjoy.

Factual Background

This case comes before the Court on undisputed facts. The parties stipulated to all the relevant facts, set forth below. The case therefore presents a pure and unsettled question of

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[1] Petitioners are proceeding by pseudonym pursuant to court order. R.14. Citations to the record are designated by docket number of the pleading "R.__" and page number, *e.g.*, "R.4 at 2".

law concerning the proper interpretation of Title III of the ADA.

Petitioners And Their Insurance With Mutual

There is no dispute that, because of their infection with HIV, Doe and Smith have physical impairments that substantially limit a number of their major life activities and that they have a disability and are regarded by Mutual as having a disability. App. 21a-22a.

Doe and Smith have health insurance with Mutual. Mutual sold Smith a health insurance policy with the following AIDS cap:

> Benefits for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Conditions (ARC) are subject to all certificate provisions, except for Restoring the Maximum Benefit provision. Benefits are limited to a Lifetime Maximum of $25,000.00 for each insured person. Once the Lifetime Maximum has been paid, any further expense incurred for AIDS or ARC will not be paid nor will it be used toward satisfying the Deductible or the Out-of-Pocket Expense Amount.

Mutual sold Doe a policy that contains the same AIDS cap, except that Doe's lifetime benefits maximum is $100,000. Mutual applies its AIDS caps to all expenses relating to HIV. App. 20a-21a.

Under Petitioners' policies, Mutual provides general benefits for medical care up to a "Lifetime Maximum" of $1,000,000. Mutual will restore this $1 million in coverage if insureds do not incur new expenses for two years. App. 20a. Mutual conceded that it denies policyholders with HIV or AIDS the full use of these benefits:

> Mutual's coverage for its insureds with AIDS and ARC is less favorable than Mutual's coverage for its other insureds. Once the AIDS Caps are reached, insureds with AIDS or ARC do not receive and cannot depend upon coverage for medical needs and treatments that are afforded to other insureds paying equivalent premiums.

App. 21a. Mutual also admitted that it will refuse to pay policyholders with HIV or AIDS even for identical treatments it otherwise covers:

> If an expense is incurred by an insured and is not related to AIDS or ARC, Mutual will cover the expense (absent another coverage exception). If the same expense related to AIDS or ARC it would be subject to the AIDS Caps. For example, Mutual will provide coverage of up to $1 million for hospitalizations and other treatment related to pneumonia unless the pneumonia presents itself as a complication of AIDS or ARC. For insureds with AIDS or ARC, these same expenses are subject to the AIDS Caps.

App. 21a.

The AIDS Caps And Insurance Risk Practices

Mutual has no legal, risk-, or cost-based rationale for the AIDS caps. It stipulated that:

> Mutual has not shown and cannot show that its AIDS Caps are or ever have been consistent with sound actuarial principles, actual or reasonably anticipated experience, bona fide risk classification, or state law.

App. 22a-23a.[2]

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[2] Petitioners also independently corroborated these facts, providing

District Court Proceedings

Petitioners' complaint invoked the district court's jurisdiction under 28 U.S.C. §§ 1331 (general federal question) and 1343 (federal civil rights) and alleged that Mutual's AIDS caps violate Title III of the ADA. On April 3, 1998, the District Court denied Mutual's motion to dismiss Petitioners' ADA claim, App. 59a-79a,[3] rejecting Mutual's argument that Title III prohibits only the denial of "access" to an insurance policy (i.e., the outright refusal to sell insurance) based on disability:

> Contrary to Mutual's suggestions, limitation of Title III's scope to the question of discriminatory access is at odds with the plain language of Title III, relevant legislative history and the Department of Justice's interpretative guidance. As an initial matter, the plain language of Title III's anti-discrimination provisions nowhere indicates that Title III's scope is limited to questions of access . . . . Title III is patently concerned with more than just access to the goods and services offered by places of public accommodation.

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evidence that Mutual's own claims experience and analyses showed that its practice of capping HIV-related care is not consistent with its treatment of other medical conditions; that the AIDS caps are unnecessary to the success of its insurance operations or the stability of its premium structure; and that most health insurance policies do not contain AIDS caps. App. 43a-45a, 47a-50a.

[3] The District Court's additional ruling that the Petitioners could not assert an implied cause of action under the Illinois Insurance Code was not appealed and is not at issue here.

App. 66a-67a. The District Court held that Mutual's AIDS caps "could plausibly constitute discrimination under any one of Title III's specific prohibitions," App. 67a, and that "to limit the scope of Title III to denials of access would effectively render the statutory language meaningless." App. 68a.

The District Court also held that the plain language of Section 501(c) manifests congressional "intent to subject insurance companies to the full scope of the ADA's anti-discrimination prohibitions," App. 71a-72a, while providing a factual defense for disability-based distinctions that are justified by "'sound actuarial principles, reasonably anticipated experience, or bona fide risk classification.'" App. 72a.[4]

Finally, the District Court ruled that the McCarran-Ferguson Act ("MFA") did not bar Petitioners' claim because, by its plain language, the MFA does not apply to federal statutes that relate to the business of insurance, and the ADA specifically relates to the business of insurance. App. 73a. In any event, the MFA applies only if construction of a federal statute would "invalidate, impair, or supersede state law," and Mutual identified no state law that would be so affected in this case. On the contrary, the District Court noted that Mutual's practice is forbidden by Illinois law. App. 73a-74a *citing* 215 ILCS 5/364.

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[4] By its terms, Section 501(c) provides a defense for certain risk-based distinctions that are "based on or not inconsistent with State law." 42 U.S.C. § 12201(c)(1), (2) (1995). Following the National Association of Insurance Commissioners' Model Regulation on Unfair Discrimination, Illinois, like other states, prohibits distinctions based on disability in the sale, terms, or conditions of insurance contracts "except where the distinction or discrimination is based on sound actuarial principles or is related to actual or reasonably anticipated experience." 215 ILCS 5/364 (1998).

Following this ruling, Mutual withdrew all remaining defenses, including any under Section 501(c), and stipulated to all relevant facts. On December 1, 1998, the District Court entered final judgment in favor of Petitioners on their ADA claim. App. 18a.

Seventh Circuit Proceedings

On June 2, 1999, a divided Seventh Circuit panel reversed the District Court's ADA and MFA rulings.

The Court's ADA Ruling

The Court of Appeals held that Section 302(a) is ambiguous but that its "core meaning" is that insurers cannot exclude individuals with disabilities from their offices or refuse to sell them insurance policies. App. 2a-3a. The majority also held that Title III prohibits insurers from providing "access" to a policy but at a higher premium, or from using policy terms "obviously designed to deter people with AIDS from buying the policy (such as refusing to cover such a person for a broken leg) . . . ." App. 10a-11a. The Court held, however, that the ADA does not otherwise reach disability-based policy terms because this would require regulation of the "content" of insurance policies. App. 9a-10a.

Analogizing invalidation of the AIDS caps to requiring a camera store to "stock cameras specially designed" for individuals with disabilities or requiring a shoe store to "sell single shoes" to a "person with one leg," the Court concluded that allowing plaintiffs to challenge disability-based coverage limits would engage the federal courts in "standardless decisions about the composition of retail inventories." App. 3a-6a. The Court recognized that Mutual's AIDS caps would be distinguishable from these comparatives and would violate the ADA if they embodied "a difference in treatment referable solely to the fact that one person is disabled and the other

not." App. 6a. But the Court concluded – despite Mutual's stipulation to the contrary – that Mutual does not really refuse to cover conditions for policyholders with HIV that it covers for all others. App. 6a-8a.

In construing the Act, the Seventh Circuit acknowledged that a statutory defense such as Section 501(c) "can cast light on what is to be defended against, that is, what the prima facie case of a violation is." App. 8a. It also recognized that the legislative history "suggests that an insurance company can limit coverage on the basis of a disability only if the limitation is based either on claims experience or on sound actuarial methods for classifying risks." App. 9a. But the Court of Appeals ultimately dismissed these indicators and concluded instead that Section 501(c) acts "just to backstop [the insurance industry's] argument that Section 302(a) regulates only access and not content." *Id.*

In contrast, the dissent viewed the case as a classic example of unlawful disparate treatment:

> [A]s I see it we are not being asked to regulate content; we are being asked to decide whether an insurer can discriminate against people with AIDS, refusing to pay for them the same expenses it would pay if they did not have AIDS. The ADA assigns to courts the task of passing judgment on such conduct.

App. 15a (Evans, J., dissenting). Finding "[t]he better analogy would be that of a store which lets disabled customers in the door, but then refuses to sell them anything but inferior cameras," App. 16a, the dissent also criticized the underpinnings of the majority's analysis:

> [The majority's analysis] doesn't come from the insurance policies. The policies don't even hint at what illnesses or afflictions might fall within the ARC exclusion. Nor has the medical community

> embraced an accepted definition for what "conditions" are "AIDS-related." The practical effect of all this, as Mutual of Omaha concedes, is that coverage for certain expenses would be approved or denied based solely on whether the insured had AIDS. Given that the ADA is supposed to signal a "clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities," *see* 42 U.S.C. §12101(b)(1), I would use the statute to right the wrong committed by Mutual of Omaha.

App. 16a-17a (Evans, J., dissenting).

The Court's McCarran-Ferguson Act Ruling

The majority alternatively held that the MFA bars Petitioners' suit. It did so despite holding that the relevant statutory sections specifically relate to the business of insurance. App. 14a. According to the Court of Appeals, the MFA barred Petitioners' ADA claim because " . . . requiring a *federal* court to decide whether an insurance policy is consistent with *state* law . . . obviously would interfere with the administration of state law." App. 13a (emphasis in original).

The dissent concluded that the MFA did not bar Petitioners' suit because any issue regarding the impairment of state law had "been taken out of the equation by Mutual of Omaha's concession in the parties' stipulation" that the AIDS caps do not comply with state law. App. 17a (Evans, J., dissenting).

Denial of Rehearing

On August 3, 1999, the Court of Appeals denied rehearing and rehearing *en banc*. App. 80a. Five of the court's ten active members voted to grant rehearing *en banc*. *Id.*

REASONS FOR GRANTING THE WRIT

The Court should resolve the split among the circuit courts on the important legal question of whether Title III ever reaches insurance policy coverage. The courts of appeals have taken at least three divergent paths in answering this question that reflect differing levels of attention to the plain language of the statute and this Court's precedents. The First and Eighth Circuits have allowed Title III challenges to discrimination in coverage to proceed; the Seventh Circuit has interpreted Title III to reach disability-based denials of access to an insurance policy but not discrimination in coverage; and the Third and Sixth Circuits have held that Title III prohibits only barriers to physical access.

Far from providing a "clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities," through "clear, strong, consistent, enforceable standards," 42 U.S.C. §§ 12101(b)(1), (2) (1995), the varied decisions of the lower courts result in confusing and inconsistent guidance for policyholders, insurance companies and public and private health care providers. The Court's intervention is needed to provide uniformity. This case presents the ideal vehicle for doing so. The parties have stipulated to the facts and there is no defense presented under Section 501(c). Mutual admits that, if subject to the ADA, its AIDS caps are indefensible. Further, the provision at issue affects only persons with HIV or AIDS. It is undisputed that Mutual's coverage distinctions single out persons with this disability, including Petitioners, for less favorable treatment.

Certiorari also is warranted because the decision below conflicts with decisions of this Court limiting the McCarran-Ferguson Act to its terms. These decisions recognize the authority of Congress intentionally to regulate the business of insurance, as the Seventh Circuit held it had in the ADA. The

Court of Appeals' decision to apply the MFA's bar in any event, and to do so where an insurer admits that its policies are inconsistent with state law, is a troubling interference with congressional authority that conflicts with this Court's previous holdings.

I. The Question Of Whether Title III Of The ADA Prohibits Disability-Based Discrimination In Coverage Merits Review.

The crux of the dispute here is whether Title III reaches beyond mere "access" to insurance offices or policies to guarantee that insurers will not arbitrarily discriminate on the basis of disability in the coverage they provide. Section 302(a) of the Act never mentions the term "access," but instead broadly requires "full and equal enjoyment" of the goods or services of places of public accommodation, including insurance offices. 42 U.S.C. §§ 12181(7)(F), 12182(a). Section 302(b), 42 U.S.C. § 12182(b), gives several examples of discriminatory deprivations of "full and equal enjoyment." As it relates to insurance, Title III is limited only by the statutory safe harbor of Section 501(c), 42 U.S.C. § 12201(c), which approves certain disability-based distinctions in insurance that "are based on or not inconsistent with State law," and which Mutual does not invoke here.

The circuit courts are split over whether Title III reaches non-exempted, disability-based coverage distinctions. This circuit split warrants review. Review is also warranted because the decision below conflicts with the ADA's plain language, legislative history, agency guidance, and prior decisions of this Court. Finally, review is warranted because of the exceptional importance of the question presented cleanly here.

A. There Is A Circuit Split As To Whether Title III Prohibits Disability-Based Coverage Distinctions.

The Seventh Circuit interpreted Title III to prohibit insurers from refusing to sell insurance policies; charging higher premiums based on disability; or using coverage terms "obviously designed to deter" persons with disabilities from purchasing policies. App. 10a. The Seventh Circuit held, however, that Title III does not otherwise prohibit disability-based discrimination in coverage provided by an insurer. The Court of Appeals' decision was the product of a divided court, and five of the ten active members of the Seventh Circuit voted to rehear the case *en banc*. App. 80a. The decision is in conflict with both the more expansive interpretation of Title III advanced by the First and Eighth Circuit Courts of Appeals, and the more restrictive interpretation of the Third and Sixth Circuits.

The first case to challenge discrimination in coverage under Title III involved the same type of insurance policy at issue here — a health insurance plan that generally provided coverage of $1 million but capped benefits for expenses relating to HIV or AIDS to a lifetime maximum of $25,000. *See Carparts Distrib. Center, Inc. v. Automative Wholesaler's Assoc. of New England*, 37 F.3d 12, 18-19 (1st Cir. 1994). Reinstating the plaintiff's Title III claim, the First Circuit rejected an "access only" interpretation and held that Title III did not merely prohibit denial of access to physical structures. While the First Circuit declined to rule further based on the record presented, courts within the First Circuit and elsewhere have applied *Carparts* to hold that Title III prohibits not only the denial of access to an insurance office or policy, but also

unjustified disability-based discrimination in insurance coverage.[5]

The Eighth Circuit also has allowed a Title III challenge to discrimination in insurance coverage. *See Henderson v. Bodine Aluminum, Inc.*, 70 F.3d 958, 960 (8th Cir. 1995). In *Henderson*, the plaintiff challenged an insurer's refusal to cover high dose chemotherapy for breast cancer while covering the same treatment for policyholders with other comparable conditions. There, as here, the plaintiff challenged a policy provision that limited coverage based on disability. Reversing the district court's denial of a preliminary injunction, the Eighth Circuit ruled that where a treatment is otherwise covered, an insurer's arbitrary denial of that treatment based on disability would violate the ADA. *See id.*

Rulings from the Third and Sixth Circuits go a third direction. These circuits have interpreted Title III to prohibit only barriers to physical access, a position they recognize to be at odds with the First Circuit. *See Parker v. Metropolitan Life Ins. Co.*, 121 F.3d 1006, 1013 (6th Cir. 1997) ("We . . . disagree with the First Circuit's decision in *Carparts* . . . ."), *cert. denied*, 118 S. Ct. 871 (1998); *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 614 (3rd Cir. 1998) (" . . . [W]e part

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[5] *See, e.g., Boots v. Northwestern Mutual Life Ins. Co.*, No. 98-625-JM, slip op. at 7, 9-10 (D.N.H. June 30, 1999) (rejecting the Sixth, Third, and Seventh Circuit's interpretations of Title III as "at odds with the law of the First Circuit"); *Doukas v. Metropolitan Life Ins. Co.*, 950 F. Supp. 422, 426 (D.N.H. 1996) (the plain language of Title III "logically extends not only to access to the good, but to the nature of the good itself."). *See also Attar v. Unum Life Ins. Co.*, No. CA3-96-CV-367-R, 1998 WL 574817, at *3 (N.D. Tex. Aug. 31, 1998); *Dunlap v. Ass'n of Bay Area Gov'ts*, 996 F. Supp. 962, 965-66 (N.D. Cal. 1998); *Chabner v. United of Omaha Life Ins. Co.*, 994 F. Supp. 1185, 1190 (N.D. Cal.), *appeal docketed*, No. CA9-98-17060 (9th Cir. 1998).

company with the First Circuit in this regard"), *cert. denied*, 119 S. Ct. 850 (1999).[6] In *Parker*, the Sixth Circuit held that Title III guarantees persons with disabilities only physical access to a place and its goods or services and that discrimination in coverage was beyond Title III's reach. 121 F.3d at 1011 n.3, 1012. *See also Lenox v. Healthwise of Kentucky, Ltd.*, 149 F.3d 453, 457 (6th Cir. 1998) (Title III does not reach disparities in health insurance coverage and requires only removal of physical barriers to access). In *Ford*, the Third Circuit expressly aligned itself with the Sixth Circuit's decision and reasoning in *Parker*.

The lead decision, *Parker*, resulted from a sharply divided *en banc* court. Five judges argued in dissent that the majority's interpretation of Title III "flies in the face" of Section 501(c), ignores legislative history, and "produces an absurd result." 121 F.3d at 1020-21 (Merritt, J., dissenting). Chief Judge Martin, who joined this dissent, also wrote separately to "emphasize [his] disagreement" with the majority's interpretation of precedent. *Id.* at 1019 (Martin, C.J., dissenting).

The disharmony among the lower courts will not be resolved until this Court rules on the core legal question of whether the ADA prohibits arbitrary, disability-based coverage distinctions. No consensus is emerging and further percolation in the lower courts stands only to shift the weight of authority to one or another of the existing positions; it will not resolve the split among the circuits on this threshold issue. Continued dissension among the lower courts frustrates the congressional purpose of providing consistent,

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[6] *Parker* and *Ford* involved challenges to benefit plans obtained through an employer and are therefore distinguishable from this case, which involves Mutual's provision of coverage directly to Doe and Smith.

enforceable standards against discrimination and calls for the Court's immediate resolution of this important question.

B. The Ruling Below Conflicts With Prior Decisions Of This Court, The ADA's Plain Language And Agency Interpretive Guidance.

Certiorari also is warranted in this case because, contrary to consistent decisions from this Court, the Seventh Circuit declined to apply the plain language of a remedial statute and substituted a limiting interpretation for that of Congress and the agencies charged with interpretation and enforcement of the ADA. *See Bragdon v. Abbott*, 524 U.S. 624, 646 (1998); *Olmstead v. L.C.*, __ U.S. __, 119 S. Ct. 2176, 2185-86 (1999). The Seventh Circuit's approach upset the balance Congress struck in Section 501(c), which allows certain coverage distinctions that are "based on or not inconsistent with State law," thereby prohibiting arbitrary distinctions not in compliance with state law.

1. The Court Has Directed Lower Courts Not To Infer Limits On The Plain Language Of Civil Rights Laws.

This Court repeatedly has reinforced the obligation of lower courts to be guided by the plain language of civil rights statutes, to redress all forms of discrimination encompassed therein and not to infer limits on Congressional purposes. *See, e.g., Olmstead*, 119 S. Ct. at 2186 (rejecting limiting interpretation of ADA Title II because "Congress had a more comprehensive view of the concept of discrimination advanced in the ADA"); *Oncale v. Sundowner Offshore Services, Inc.*, 523 U.S. 75, 79 (1998) (rejecting a "bewildering variety" of interpretations of Title VII that strayed from its language); *Haddle v. Garrison*, 525 U.S. 121

(1998) (refusing to impose a limiting construction on Section 1985(2) that was inconsistent with the species of harms Congress sought to remedy). The Seventh Circuit's approach to interpreting the ADA conflicts with this Court's holdings and merits review.

Section 302(a) does not support an "access only" reading. It prohibits a public accommodation from denying the "full and equal enjoyment" of its goods or services based on disability. As the District Court recognized, "full and equal enjoyment" is something that occurs *after* one gains access to a good or service or, as in this case, as one uses the services of the insurance office. App. 67a-68a.

Section 302(b) contains several examples of how this discriminatory deprivation of "full and equal enjoyment" can manifest. These include denying the opportunity to "participate in or benefit from" goods or services provided to others, or "providing goods or services "that [are] not equal to," or are "different or separate from" those provided to others. *See* p. 2-3, *supra*. Section 302(b)(2) further prohibits the use of eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from "fully and equally enjoying" any goods or services.

If there remained any doubt that this "full and equal enjoyment" requirement reaches Mutual's insurance coverage, Section 501(c) removes it. Sections 501(c)(1) and (2) provide a safe harbor for "underwriting," "classifying," or "administering" risks, and for establishing or administering plans "that are based on or not inconsistent with State law" and not otherwise an attempt "to evade the purposes of [the ADA]." *See* p. 3-4, *supra*. These provisions would be utterly superfluous if Title III did not reach insurance distinctions, *see Astoria Fed. Sav. and Loan Ass'n v. Solimino*, 501 U.S. 104, 112 (1991) ("But of course we construe statutes, where

possible, so as to avoid rendering superfluous any parts thereof"), and make sense only if distinctions that do not come within Section 501(c)'s safe harbor remain subject to "the full scope of the ADA's anti-discrimination prohibitions." App. 71a-72a. The Seventh Circuit's analysis violates this Court's instructions and results in an artificially limited construction of a remedial statute.

2. Reasonable Agency Guidance And The ADA's Legislative History Confirm That The ADA Prohibits Mutual's AIDS Caps.

Even if the ADA's plain language did not unambiguously answer the question, interpretive guidance from the Department of Justice ("DOJ") makes clear that Title III applies to and prohibits disability-based discrimination in insurance coverage: "Insurance offices are places of public accommodation and, as such, may not discriminate on the basis of disability in the sale of insurance contracts or in the terms or conditions of the insurance contracts they offer." Department of Justice Title III Technical Assistance Manual § III-3.11000 (1993). The DOJ specifically considered and rejected the view that Title III should not apply to insurance practices. 28 C.F.R. § 36.212, App. B. at 601 ("Only a few commenters argued that the Act does not apply to insurance underwriting practices or the terms of insurance contracts. . . .Congress intended to reach insurance practices by prohibiting differential treatment of individuals with disabilities in insurance offered by public accommodations unless the differences are justified.").

The position the DOJ has taken in its regulations, technical assistance manual, and authoritative briefs filed in this case is consistent with that of the Equal Employment

Opportunity Commission,[7] *see Bragdon*, 524 U.S. at 646 ("[w]e also draw guidance from the views of the agencies authorized to administer other sections of the ADA"), and warrants deference. *See id.; Olmstead*, 119 S. Ct. at 2186 ("Because the Department is the agency directed by Congress to issue regulations . . . its views warrant respect.").[8]

The DOJ's interpretation is true to the Act's legislative history. Committee reports explaining Section 501(c) illustrate Congress' understanding that the ADA reaches and broadly prohibits unjustified distinctions in insurance coverage:

> While a plan which limits certain kinds of coverage based on classification of risk would be allowed under [Section 501(c)], the plan may not refuse to insure, or refuse to continue to insure, *or limit the amount, extent, or kind of coverage* available to an individual, or charge a different rate for the same

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[7] *See* Bureau of National Affairs, American with Disabilities Act Manual, *EEOC: Interim Policy Guidance on ADA and Health Insurance* 70 (1993) (a "lower AIDS cap is a disability-based distinction" that violates the ADA unless justified under Section 501(c)). The EEOC has identified AIDS caps as a prohibited form of discrimination since 1993 and has brought 14 trial level challenges to HIV/AIDS caps contained in group insurance policies, all of which were resolved in favor of the plaintiffs through settlement or consent decree. *EEOC Docket of ADA Litigation*, Trial Docket -- Resolved Cases (visited Oct. 19, 1999), <http://www.eeoc.gov/docs/ada98.txt>.

[8] In a case challenging implementation of an AIDS cap under ERISA, the Solicitor General likewise expressed the view that the ADA, which had just taken effect but had not been enacted when plaintiff brought suit, would prohibit AIDS caps that did not come within Section 501(c). *See Brief for the United States as Amicus Curiae* at 17-18, *Greenberg v. H&H Music Co.*, 503 U.S. 958 (1992) (No. 91-1283) (inviting the Solicitor General to file a brief), *cert. denied*, 506 U.S. 981 (1992).

> coverage solely because of a physical or mental impairment, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

H.R. Rep. No. 101-485, pt. II, at 136-37 (1990) (emphasis added).[9] The Seventh Circuit, in selectively choosing what forms of discrimination to recognize as illegal, did not give full effect to Title III or congressional intent.

3. Prior Decisions Of This Court Apply Civil Rights Laws To Coverage Distinctions.

This Court previously has applied federal civil rights laws, including the Rehabilitation Act, to coverage distinctions in a variety of contexts. *See, e.g., Alexander v. Choate*, 469 U.S. 287 (1985); *Arizona Governing Comm. for Tax Deferred Annuity & Deferred Comp. Plans v. Norris*, 463 U.S. 1073 (1983); *Los Angeles Water and Power v. Manhart*, 435 U.S. 702 (1978). These rulings establish that coverage distinctions based on a prohibited characteristic like sex, race, or disability that result in disparate treatment are a prohibited form of discrimination. Congress enacted the ADA against this backdrop and specifically incorporated the standards established under the Rehabilitation Act into the ADA, signaling its understanding that the ADA's broad prohibitions would reach discrimination in insurance coverage. 42 U.S.C. § 12201(a); *Bragdon*, 524 U.S. at 646.

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[9] *See also* S. Rep. No. 101-116 at 84 (1989) ("Virtually all States prohibit unfair discrimination among persons of the same class and equal expectation of life. The [ADA] adopts this prohibition of discrimination.").

In *Choate*, plaintiffs challenged Tennessee's proposal to reduce coverage for inpatient hospital care under its state Medicaid program as a violation of the Rehabilitation Act. 469 U.S. at 289-90. Unlike Mutual's AIDS caps, which explicitly target only insureds with HIV and AIDS for disparate treatment, the coverage limit in *Choate* applied to all program participants without regard to disability. The Court allowed Tennessee's facially neutral policy because it "does not apply to only particular handicapped conditions and takes effect regardless of the particular cause of hospitalizations."[10] *Id.* at 302 n.22. The Court recognized, however, that anti-discrimination legislation can be "'emptied of meaning'" by the manner in which coverage is defined as much as by the outright denial of access to coverage and held that "[t]he benefit itself, of course, cannot be defined in a way that effectively denies otherwise qualified handicapped individuals the meaningful access to which they are entitled . . . ." *Id.* at 301 (footnote omitted). This is what Mutual has done here by defining coverage to result in "a difference in treatment referable solely to the fact that one person is disabled and the other not." App. 6a.

Likewise, the Seventh Circuit's view that only discrimination in the offer or sale of insurance is actionable under the ADA conflicts with this Court's guidance in *Norris*, 463 U.S. at 1078. In *Norris*, female employees brought suit under Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e *et seq.*, challenging a state pension plan that was offered to all employees. Although the identical plan was offered on the same terms to men and women, one pay-out option paid lower monthly benefits to women upon retirement

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[10] This case does not present any issue as to whether or to what extent disparate impact claims may be used to challenge insurance discrimination under the ADA. Mutual's policies discriminate against insureds with HIV or AIDS by "design." *Choate*, 469 U.S. at 292.

than to men. *See Norris*, 469 U.S. at 1076-79. This Court held that, even though all employees were granted access to the same plan, the different treatment in coverage under the benefit plan constituted unlawful discrimination on the basis of sex: "We have no hesitation in holding . . . that the classification of employees on the basis of sex is no more permissible at the pay-out stage of a retirement plan than at the pay-in stage." *Id.* at 1081 (footnotes omitted). The Court of Appeals' refusal to scrutinize Mutual's classification of insureds with HIV or AIDS upon determining there was no discrimination in the offer or sale of the policy conflicts with *Choate* and *Norris*.

The Seventh Circuit's narrow view of prohibited discrimination also conflicts with this Court's recent interpretations of the ADA. *See Bragdon*, 524 U.S. at 628, 648; *Olmstead*, 119 S. Ct. at 2188 n.14. The dentist in *Bragdon* granted a patient with HIV access to his dental office, examined her teeth, determined she had a cavity, and even offered to fill her cavity, albeit not in his office. 524 U.S. at 628. The discrimination came in denying a service he made available to other clients, having the cavity filled at his office, and instead offering to fill her cavity only at a hospital. The Seventh Circuit's reasoning would approve such conduct, but this Court found that, absent a statutory defense, it violates Title III. *Id.* In *Olmstead*, the Court affirmed that while the ADA does not mandate what services will be provided, plan providers "must adhere to the ADA's non-discrimination requirement with regard to the service they in fact provide." 119 S. Ct. at 2188 n.14.[11] These decisions

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[11] Mutual's admitted refusal to provide policyholders with HIV or AIDS coverage for identical treatments that it provides all other insureds — both those with other disabilities and those without disabilities — also would constitute unlawful discrimination as defined in the *Olmstead* concurrence and dissent. See *Olmstead*, 119 S. Ct. at 2192-93 (Kennedy, J.,

confirm that purportedly equal "access" to facially discriminatory coverage may not be used to evade the ADA's prohibition on discrimination.

C. The Case Presents A Question Of Fundamental Importance.

Whether Title III can be interpreted to provide only the barest protection against insurance discrimination for persons with disabilities — access to facially discriminatory coverage — is an issue of exceptional importance. In passing the ADA, Congress sought to ensure "full participation, independent living, and economic self-sufficiency" to persons with disabilities, and to reduce "dependency and nonproductivity" that results from "unfair and unnecessary discrimination and prejudice." 42 U.S.C. § 12101(a)(8), (9). By granting insurers license to create arbitrary coverage distinctions, the decision below undermines these goals and has devastating implications for all persons with disabilities.

Disability-based coverage caps dramatically reduce access to benefits and force individual policyholders to make risky choices regarding their health care such as those Petitioners Doe and Smith already have had to make. For example, they have participated in experimental drug trials, foregone recommended testing, and reduced physician visits in order to save room under the cap for future needs. App. 34a-35a, 40a-41a. They have taken these risks because they know that, once the AIDS caps are reached, they will have no coverage for critical medical needs including combination drug therapies that reduce the level of HIV and delay progression of the disease.

Once the AIDS caps are exhausted, policyholders with HIV or AIDS may be forced to rely on public health

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concurring); *id.* at 2196 (Thomas, J., dissenting).

insurance programs, such as Medicaid and Medicare. Only a small percentage of persons with public insurance receive medical care from private physicians and few are able to maintain an ongoing relationship with a primary care provider. *See Brief Amicus Curiae of the Infectious Diseases Society of America et al.* at 22-24, *Doe and Smith v. Mutual of Omaha Ins. Co.*, 179 F.3d 557 (7th Cir. 1999) (No. 98-4112). As a result, persons with public insurance are less likely to receive preventive care; and the health care they eventually require, often obtained in hospitals or emergency rooms, is more expensive. *Id.* at 23, 25-26.

The consequences of this uncertainty about coverage for critical health care are potentially devastating to Petitioners and to the public health. As Dr. Novak testified in his affidavit, even a short interruption in drug therapy can lead to the development of drug-resistant strains of HIV that will not respond to medications. App. 29a.

Given the high stakes for individuals with disabilities whose health is at risk, challenges to arbitrary discrimination in insurance coverage will not end before this Court answers the fundamental question of whether disability-based distinctions in coverage are subject to the ADA. In the intervening time, and for as long as this question goes unaddressed by this Court, policyholders will remain uncertain about coverage for necessary health care and insurance companies will be unable to determine their responsibilities and potential liability under the Act. The Court should take the opportunity to end this uncertainty by granting review and resolving the split among the circuit courts.

D. This Case Presents The Ideal Vehicle For Resolving This Important Question.

The extent to which Title III protects individuals with disabilities from discrimination by insurance companies will be resolved fully in the years to come. Lower courts are grappling now with questions about the ADA's application to insurance in a variety of contexts that present multiple legal and factual issues. But this case cleanly presents the threshold issue that has emerged from these cases: whether Title III ever prohibits admittedly unjustifiable disability-based discrimination in policy coverage.

The parties have stipulated to all relevant facts. Mutual concedes that its AIDS caps do not come within Section 501(c)'s safe harbor and has withdrawn any possible defense under that provision. App. 25a. Compliance with state law is therefore not an issue, and Mutual's stipulation that its AIDS caps are not consistent with "sound actuarial principles, actual or reasonably anticipated experience, [or] bona fide risk classification," removes any assessment of these terms from this case.

Rather, the AIDS Cap provision presents a classic case of disability-based discrimination. Mutual's AIDS caps affect only persons with HIV or AIDS and result in less favorable coverage than is provided to all others. App. 21a. Mutual stipulated that it will deny coverage for identical treatments, such as hospitalizations and treatments for pneumonia, based solely on an insured's disability with HIV. *Id.* The Court should take the opportunity presented by this case to hold that a provision that singles out insureds with a particular disability like HIV or AIDS for disparate treatment, without any justification for doing so, is unlawful disability-based discrimination.

II. The Seventh Circuit's McCarran-Ferguson Act Ruling Conflicts With This Court's Prior Decisions And The MFA's Plain Language.

The Court also should grant *certiorari* to overturn the Court of Appeals' conclusion that although the ADA expressly relates to the business of insurance, the MFA bars application of the ADA in this case because such application would impair state insurance regulation. App. 12a-14a. The majority's ruling is irreconcilable with prior, unanimous decisions of this Court and the plain language of the MFA.

The purpose of the MFA is to ensure that silence in federal law as to insurance matters is not errantly construed to override state insurance regulation. *Humana Inc. v. Forsyth*, 525 U.S. 299, 119 S. Ct. 710 (1999). Far from ceding the field of insurance regulation to the States, Congress made clear that it remains free to regulate insurance at will; it need only signal its intent to reach insurance to do so. *Barnett Bank v. Nelson*, 517 U.S. 25, 38 (1996) ("By its terms, however, the [MFA] does not apply when the conflicting federal statute 'specifically relates to the business of insurance'"); *Humana*, 119 S. Ct. at 717 ("We reject any suggestion that Congress intended to cede the field of insurance regulation to the States . . . ."). Congress clearly signaled its intent to reach the business of insurance under the ADA. Insurance offices are listed public accommodations and Section 501(c) plainly applies to risk-based practices. Laws that affect the relationship of insured and insurer or the "spreading of risk" have been held specifically to relate to the business of insurance. *Barnett Bank*, 517 U.S. at 39. Even the Court of Appeals below recognized that Section 501(c), which expressly directs the construction of Title III, specifically relates to the business of insurance, and "accept[ed] (certainly for purposes of argument) that Section 302(a)" does so as well. App. 14a.

The Seventh Circuit's holding that the ADA relates to the business of insurance should have ended its MFA analysis. *See Barnett Bank*, 517 U.S. at 38, 40-42. Instead, the Seventh Circuit grafted a further, unprecedented requirement onto the MFA, invalidating even those federal laws that specifically relate to the business of insurance if they might impair state insurance regulation. App. 13a-14a. This ruling shackles Congressional authority in a manner that this Court has rejected. *Barnett Bank*, 517 U.S. at 40. Nothing in the MFA is meant to limit the intentional exercise of federal jurisdiction over insurance matters.

Moreover, application of the ADA to Mutual's AIDS caps would not "invalidate, impair, or supersede" state law. Mutual concedes the AIDS caps do not comply with state law. Thus, even were it a relevant consideration, there simply is no state law interference here. The majority wrongly focused on other possible scenarios, see *Humana*, 119 S. Ct. at 719 n.12, and concluded that application of the ADA here might "impair" state law in a hypothetical future case in which the court might be called upon to determine compliance with state law. App. 13a-14a. Even then, the majority's sole concern was that federal rather than state courts might be called upon to determine whether an insurance practice complies with state law. App. 13a. But this does not itself constitute an impairment of state law. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105-06 (1983) (requiring state courts to determine compliance with federal law is not itself an impairment of federal law); *Humana*, 119 S. Ct. at 717-18 (adopting *Shaw* impairment analysis). Federal courts regularly interpret state law (*e.g.*, in diversity cases or where federal law incorporates a state statute of limitation) without impairing state law. The Seventh Circuit's MFA ruling is deeply flawed, conflicts with several decisions of this Court, and should be reviewed and reversed.

CONCLUSION

For all the foregoing reasons, the petition for a writ of *certiorari* should be granted.

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Dated: November 1, 1999

APPENDIX

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filed under separate cover. Each excerpted document has been bracketed in this table and can be found in the Separate Appendix at the indicated page number ("_b").

John DOE and Richard SMITH, Plaintiffs-Appellees,

v.

MUTUAL OF OMAHA INSURANCE COMPANY, Defendant-Appellant.

No. 98-4112.

United States Court of Appeals,
Seventh Circuit.

Argued April 5, 1999.
Decided June 2, 1999.
Rehearing and Suggestion for Rehearing En Banc Denied Aug. 3, 1999.

Before POSNER, *Chief Judge*, and EASTERBROOK and EVANS, *Circuit Judges*.

POSNER, *Chief Judge*. Mutual of Omaha appeals from a judgment that the AIDS caps in two of its health insurance policies violate the public accommodations provision of the Americans with Disabilities Act. One policy limits lifetime benefits for AIDS or AIDS-related conditions (ARC) to $25,000, the other limits them to $100,000 , while for other conditions the limit in both policies is $1 million. Mutual of Omaha has stipulated that it "has not shown and cannot show that its AIDS Caps are or ever have been consistent with sound actuarial principles, actual or reasonably anticipated experience, bona fide risk classification, or state law." It also concedes that AIDS is a disabling condition within the meaning of the Americans with Disabilities Act. See *Bragdon v. Abbott*, 524 U.S. 624, 118 S. Ct. 2196, 2207-09, 141 L.Ed.2d 540 (1998); *Doe v. Dekalb County School District*, 145 F.3d 1441, 1445 n. 5 (11th Cir.1998). Since the Supreme Court held in *Bragdon* that infection with the AIDS virus

(HIV) is a disabling condition from the onset of the infection, 118 S. Ct. at 2204, before any symptoms appear, it is apparent that both ARC and AIDS are disabilities. Mutual of Omaha does not question this, but argues only that the Americans with Disabilities Act does not regulate the content of insurance policies.

Title III of the Act, in section 302(a), provides that "no individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation" by the owner, lessee, or operator of such a place. 42 U.S.C. § 12182(a). The core meaning of this provision, plainly enough, is that the owner or operator of a store, hotel, restaurant, dentist's office, travel agency, theater, Web site, or other facility (whether in physical space or in electronic space, *Carparts Distribution Center, Inc. v. Automotive Wholesaler's Ass'n of New England, Inc.*, 37 F.3d 12, 19 (1st Cir.1994)) that is open to the public cannot exclude disabled persons from entering the facility and, once in, from using the facility in the same way that the nondisabled do. The owner or operator of, say, a camera store can neither bar the door to the disabled nor let them in but then refuse to sell its cameras to them on the same terms as to other customers. E.g., *Johnson v. Gambrinus Co./Spoetzl Brewery*, 116 F.3d 1052 (5th Cir.1997); *Paralyzed Veterans of America v. D.C. Arena L.P.*, 117 F.3d 579 (D.C. Cir.1997); Department of Justice, Civil Rights Division, *The Americans with Disabilities Act: Title III Technical Assistance Manual* § III- 3.2000 (Nov.1993); 28 C.F.R. § 36.202. To come closer to home, a dentist cannot refuse to fill a cavity of a person with AIDS unless he demonstrates a direct threat to safety or health, *Bragdon v. Abbott*, *supra*, 118 S. Ct. at 2210-13; *Koshinski v. Decatur Foundry, Inc.*, 177 F.3d 599 (7th Cir.1999), and an

insurance company cannot (at least without pleading a special defense, discussed below) refuse to sell an insurance policy to a person with AIDS. 28 C.F.R. § 36.104 Place of Public Accommodation (6). Mutual of Omaha does not refuse to sell insurance policies to such persons--it was happy to sell health insurance policies to the two plaintiffs. But because of the AIDS caps, the policies have less value to persons with AIDS than they would have to persons with other, equally expensive diseases or disabilities. This does not make the offer to sell illusory, for people with AIDS have medical needs unrelated to AIDS, and the policies give such people as much coverage for those needs as the policies give people who don't have AIDS. If all the medical needs of people with AIDS were AIDS-related and thus excluded by the policies, this might support an inference that Mutual of Omaha was trying to exclude such people, and such exclusion, as we shall see, might violate the Act. But that is not argued.

Since most health-insurance policies contain caps, the position urged by the plaintiffs would discriminate among diseases. Diseases that happened to be classified as disabilities could not be capped, but equally or more serious diseases that are generally not disabling, such as heart disease, could be. Moreover, the plaintiffs acknowledge the right of an insurance company to exclude coverage for an applicant's pre-existing medical conditions. If the applicant is already HIV-positive when he applies for a health-insurance policy, the insurer can in effect cap his AIDS-related coverage at $0. This "discrimination" is not limited to AIDS or for that matter to disabilities, which is why the plaintiffs do not challenge it; but it suggests that the rule for which they contend is at once arbitrary and unlikely to do much for people with AIDS.

The insurance company asks us to compare this case

to one in which a person with one leg complains of a shoestore's refusal to sell shoes other than by the pair, or in which a blind person complains of a bookstore's refusal to stock books printed in Braille. We do not understand the plaintiffs to be contending that such complaints are actionable under section 302(a), even though there is a sense in which the disabled individual would be denied the full and equal enjoyment of the services that the store offers. In fact, it is apparent that a store is not required to alter its inventory in order to stock goods such as Braille books that are especially designed for disabled people. *Lenox v. Healthwise of Kentucky, Ltd.*, 149 F.3d 453, 457 (6th Cir.1998); 28 C.F.R. § 36.307. But it is apparent as a matter of interpretation rather than compelled by a simple reading which would place the present case on the other side of the line; and so the case cannot be resolved by reference simply to the language of section 302(a).

The common sense of the statute is that the content of the goods or services offered by a place of public accommodation is not regulated. A camera store may not refuse to sell cameras to a disabled person, but it is not required to stock cameras specially designed for such persons. Had Congress purposed to impose so enormous a burden on the retail sector of the economy and so vast a supervisory responsibility on the federal courts, we think it would have made its intention clearer and would at least have imposed some standards. It is hardly a feasible judicial function to decide whether shoestores should sell single shoes to one-legged persons and if so at what price, or how many Braille books the Borders or Barnes and Noble bookstore chains should stock in each of their stores. There are defenses to a prima facie case of public-accommodation discrimination, but they would do little to alleviate the judicial burden of making standardless decisions about the

composition of retail inventories. The only defense that might apply to the Braille case or the pair of shoes case is that the modification of a seller's existing practices that is necessary to provide equal access to the disabled "would fundamentally alter the nature of ... [the seller's] services," 42 U.S.C. § 12182(b)(2)(A)(ii), and it probably would not apply to either case and certainly not to the Braille one.

The plaintiffs might be able to distinguish the shoestore hypothetical by pointing out that a nondisabled person might be in the market for one shoe simply because he had lost a shoe; in refusing to sell single shoes the store thus would not be refusing to adapt its service to a class of customers limited to disabled people. But the Braille case, and many others that we can imagine (such as a furniture store's decision not to stock wheelchairs, or a psychiatrist's refusal to treat schizophrenia, as distinct from his refusing to treat schizophrenics for the psychiatric disorders in which he specializes, or a movie theater's refusal to provide a running translation into sign language of the movie's soundtrack), cannot be so distinguished, although some of them might find shelter in the "fundamental alteration" defense. All are cases of refusing to configure a service to make it as valuable to a disabled as to a nondisabled customer.

That the plaintiffs are asking that a limitation be removed rather than that a physical product be added or altered cannot distinguish these cases. For the same thing is true in our example of the psychiatrist who refuses to treat schizophrenia. More important, since section 302(a) is not limited to physical products, but includes contracts and other intangibles, such as an insurance policy, a limitation upon the duty to serve cannot be confined to physical changes. An insurance policy is a product, and a policy with a $25,000 limit is a different product from one with a $1 million limit,

just as a wheelchair is a different product from an armchair. A furniture store that does not stock wheelchairs knows that it is making its services less valuable to disabled than to nondisabled people, but the Americans with Disabilities Act has not been understood to require furniture stores to stock wheelchairs.

It might seem that the AIDS caps could be distinguished from the "refusal to stock" cases because the caps include complications of AIDS. If being infected by HIV leads one to contract pneumonia, the cost of treating the pneumonia is subject to the AIDS cap; if a person not infected by HIV contracts pneumonia, the costs of treating his pneumonia are fully covered. It looks, therefore, like a difference in treatment referable solely to the fact that one person is disabled and the other not.

But this is not correct. The essential point to understand is that HIV doesn't cause illness directly. What it does is weaken and eventually destroy the body's immune system. As the immune system falters, the body becomes prey to diseases that the system protects us against. These "opportunistic" diseases that HIV allows, as it were, to ravage the body are exotic cancers and rare forms of pneumonia and other infectious diseases. Anthony S. Fauci & H. Clifford Lane, "Human Immunodeficiency Virus (HIV) Disease: AIDS and Related Disorders," in 2 *Harrison's Principles of Internal Medicine* 1791, 1824-45 (Anthony S. Fauci et al. eds., 14th ed.1998). To refer to them as "complications" of HIV or AIDS is not incorrect, but it is misleading, because they are the chief worry of anyone who has the misfortune to be afflicted with AIDS. An AIDS cap would be meaningless if it excluded the opportunistic diseases that are the most harmful consequences of being infected by the AIDS virus.

What the AIDS caps in the challenged insurance policies cover, therefore, is the cost of fighting the AIDS virus itself and trying to keep the immune system intact plus the cost of treating the opportunistic diseases to which the body becomes prey when the immune system has eroded to the point at which one is classified as having AIDS. The principal opportunistic diseases of AIDS, such as Kaposi's sarcoma, *Pneumocystis carinii* pneumonia, AIDS wasting, and esophageal candidiasis, are rarely encountered among people who are not infected by HIV--so rarely as to be described frequently as "AIDS-defining opportunistic infections." *Id.* at 1818. The frequency of *Pneumocystis carinii* pneumonia, for example, "among patients infected with human immunodeficiency virus (HIV) far exceeds that among other immuno-compromised hosts" and is "a leading cause of opportunistic infection and death among AIDS patients in industrialized countries." Peter D. Walzer, "*Pneumocystis Carinii* Infection," in 1 Harrison's, *supra*, at 1161. It is these *distinctive* diseases that are the target (along with the costs of directly treating infection by HIV) of the AIDS caps. This is not a case of refusing, for example, to provide the same coverage for a broken leg, or other afflictions not peculiar to people with AIDS, to such people, which would be a good example of discrimination by reason of disability.

It is true that as the immune system collapses because of infection by HIV, the patient becomes subject to opportunistic infection not only by the distinctive AIDS-defining diseases but also by a host of diseases to which people not infected with HIV are subject. Even when they are the same disease, however, they are far more lethal when they hit a person who does not have an immune system to fight back with. Which means they are not really the same disease. This is not a point that is peculiar to AIDS. The end

stage of many diseases is an illness different from the one that brought the patient to that stage; nowadays when a person dies of pneumonia, it is usually because his body has been gravely weakened by some other ailment. If a health insurance policy that excluded coverage for cancer was interpreted not to cover the pneumonia that killed a patient terminally ill with cancer, this would not be "discrimination" against cancer.

To summarize the discussion to this point, we cannot find anything in the Americans with Disabilities Act or its background, or the nature of AIDS and AIDS caps, to justify so radically expansive an interpretation as would be required to bring these cases under section 302(a) without making an unprincipled distinction between AIDS caps and other product alterations-- unless it is section 501(c)(1) of the Act. That section provides that Title I (employment discrimination against the disabled) and Title III (public accommodations, the title involved in this case) "shall not be construed to prohibit or restrict an insurer ... from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law," 42 U.S.C. § 12201(c)(1), unless the prohibition or restriction is "a subterfuge to evade the purposes" of either title. § 12201(c). Even with the "subterfuge" qualification, section 501(c) is obviously intended for the benefit of insurance companies rather than plaintiffs and it may seem odd therefore to find the plaintiffs placing such heavy weight on what is in effect a defense to liability. But a defense can cast light on what is to be defended against, that is, what the prima facie case of a violation is. Suppose, for example, that a statute regulated the sale of "animals" but it was unclear whether the legislature had meant to include fish. Were there a statutory exclusion for goldfish, it would be pretty clear that "animals" included fish, since otherwise there would be no occasion for

such an exclusion. And, with that clarified, the advocate of regulating the sale of a particular goldfish would have to show only that the exclusion was somehow inapplicable to him. That is the plaintiffs' strategy here. They use the insurance provision to show that section 302(a) regulates content, then argue that the excluding provision is narrow enough to allow them to challenge the coverage limits in Mutual of Omaha's policies. There is even some legislative history, which the plaintiffs hopefully call "definitive," to section 501(c) that suggests that an insurance company can limit coverage on the basis of a disability only if the limitation is based either on claims experience or on sound actuarial methods for classifying risks. H.R. Rep. No. 485, 101st Cong., 2d Sess. 136-37 (1990); S. Rep. No. 116, 101st Cong., 1st Sess. 84-86 (1989). And Mutual of Omaha conceded itself out of relying on section 501(c)'s safe harbor by stipulating that it cannot show that its AIDS caps are based on sound actuarial principles or claims experience or are consistent with state law.

The plaintiffs argue, consistent with our goldfish example, that the insurance exemption has no function if section 302(a) does not regulate the content of insurance policies, and so we should infer that the section does regulate that content. But this reasoning is not correct. If it were, it would imply that section 302(a) regulates the content not only of insurance policies but also of all other products and services, since the section is not limited to insurance. The insurance industry may have worried that the section would be given just the expansive interpretation that the district court gave it in this case, and so the industry may have obtained the rule of construction in section 501(c) just to backstop its argument that section 302(a) regulates only access and not content. Or it may have worried about being sued under section 302(a) for refusing to sell an insurance

policy to a disabled person. Remember that the right of full and equal enjoyment as we interpret it includes the right to buy on equal terms and not just the right to enter the store. For Mutual of Omaha to take the position that people with AIDS are so unhealthy that it won't sell them health insurance would be a prima facie violation of section 302(a). But the insurance company just might be able to steer into the safe harbor provided by section 501(c), provided it didn't run afoul of the "subterfuge" limitation, as it would do if, for example, it had adopted the AIDS caps to deter people who know they are HIV positive from buying the policies at all.

The legislative history is consistent with this interpretation. Both committee reports on which the plaintiffs rely give the example of refusing to sell an insurance policy to a blind person, as does the gloss placed on section 501(c) by the Department of Justice. 28 C.F.R. Pt. 36, App. B § 36.212, p. 601 (1998). A refusal to sell insurance to a blind person is not the same thing as a provision in the policy that if the insured becomes blind, the insurer will not pay the expense of his learning Braille. We find nothing in the language or history of the statute to suggest that the latter refusal would be unlawful. The Department's *Technical Assistance Manual*, *supra*, § III-3.11000, contains somewhat broader language than either the statute or the regulation or the committee reports, language about insurers' being forbidden to discriminate on the basis of disability in the sale, terms, or conditions of insurance contracts; but basically this just parrots the statute and the regulation and does not indicate a focused attention to coverage limits. There is, as we have pointed out, a difference between refusing to sell a health-insurance policy at all to a person with AIDS, or charging him a higher price for such a policy, or attaching a condition obviously designed to deter people with AIDS from buying the policy (such as

refusing to cover such a person for a broken leg), on the one hand, and, on the other, offering insurance policies that contain caps for various diseases some of which may also be disabilities within the meaning of the Americans with Disabilities Act.

The Department has filed an amicus curiae brief that effaces this distinction and embraces the plaintiffs' interpretation of the Act. The Department's regulations interpreting the Americans with Disabilities Act are entitled to *Chevron* deference, *Bragdon v. Abbott*, *supra*, 118 S. Ct. at 2209; *Paralyzed Veterans of America v. D.C. Arena L.P.*, *supra*, 117 F.3d at 588, but, as we have just seen, do not compel the interpretation for which these plaintiffs contend. We noted recently, in *Commonwealth Edison Co. v. Vega*, 174 F.3d 870, 874-75, (7th Cir.1999), that it is unsettled how much Chevron deference is to be given to an agency's informal policy pronouncements. This category includes the *Technical Assistance Manual* as well as the amicus curiae brief; and though we know from *Auer v. Robbins*, 519 U.S. 452, 462, 117 S. Ct. 905, 137 L.Ed.2d 79 (1997), that, in some circumstances at least, an agency's amicus brief is entitled to some deference, it cannot be very great when it is the brief of an agency that has, and has exercised, rulemaking powers yet has unaccountably failed to address a fundamental issue on which the brief takes a radical stance. Cf. *Paralyzed Veterans of America v. D.C. Arena L.P.*, *supra*, 117 F.3d at 588-89. Displacing the regulation of the insurance industry into the federal courts is a sufficiently far-reaching interpretive stride to justify us in requiring the Department to invite deference by a more deliberative, public, and systematic procedure than the filing of an amicus curiae brief. Such a brief in such circumstances cannot claim much democratic legitimacy to set over against the intent of Congress so far as it can be gleaned from the usual

interpretive sources--which do not include the brief of one of the parties!

We conclude that section 302(a) does not require a seller to alter his product to make it equally valuable to the disabled and to the nondisabled, even if the product is insurance. This conclusion is consistent with all the appellate cases to consider this or cognate issues. *Vaughn v. Sullivan*, 83 F.3d 907, 912-13 (7th Cir.1996); *Rogers v. Department of Health & Environmental Control*, 174 F.3d 431 (4th Cir.1999); *Parker v. Metropolitan Life Ins. Co.*, 121 F.3d 1006, 1010-14 (6th Cir.1997) (en banc); *Lenox v. Healthwise of Kentucky, Ltd.*, *supra*; *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 612-14 (3d Cir.1998); cf. *Modderno v. King*, 82 F.3d 1059 (D.C. Cir.1996). And if it is wrong, the suit must fail anyway, because it is barred by the McCarran-Ferguson Act.

That Act, so far as bears on this case, forbids construing a federal statute to "impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance ... unless such Act specifically relates to the business of insurance." 15 U.S.C. § 1012(b). Direct conflict with state law is not required to trigger this prohibition; it is enough if the interpretation would "interfere with a State's administrative regime." *Humana Inc. v. Forsyth*, 525 U.S. 299, ----, 119 S. Ct. 710, 717, 142 L.Ed.2d 753 (1999); *Department of the Treasury v. Fabe*, 508 U.S. 491, 113 S. Ct. 2202, 124 L.Ed.2d 449 (1993); *Autry v. Northwest Premium Services, Inc.*, 144 F.3d 1037, 1039-44 (7th Cir.1998). The interpretation of section 302(a) of the Americans with Disabilities Act for which the plaintiffs contend would do this. State regulation of insurance is comprehensive and includes rate and coverage issues, see Lee R. Russ & Thomas F. Segalla, *Couch on Insurance* §§ 2:7,

2:20, 2:26, 2:35 (3d ed.1997), so if federal courts are now to determine whether caps on disabling conditions (by no means limited to AIDS) are actuarially sound and consistent with principles of state law they will be stepping on the toes of state insurance commissioners.

It is one thing to say that an insurance company may not refuse to deal with disabled persons; the prohibition of such refusals can probably be administered with relatively little interference with state insurance regulation, *NAACP v. American Family Mutual Ins. Co.*, 978 F.2d 287 (7th Cir.1992), and anyway this may be a prohibition expressly imposed by federal law because encompassed within the blanket prohibition of section 302(a) of the Americans with Disabilities Act, and so outside the scope of the McCarran-Ferguson Act. It is another thing to require federal courts to determine whether limitations on coverage are actuarially sound and consistent with state law. Even if the formal criteria are the same under federal and state law, displacing their administration into federal court--requiring a *federal* court to decide whether an insurance policy is consistent with *state* law--obviously would interfere with the administration of the state law. The states are not indifferent to who enforces their laws. For the converse situation, of forbidden interference by the states in the administration of federal programs, see *Commonwealth Edison Co. v. Vega*, *supra*, 174 F.3d 870, 872-74.

It is true that we are not being asked *in this case* to decide whether the AIDS caps were actuarially sound and in accordance with state law. But if the McCarran-Ferguson Act does not apply, then we are certain to be called upon to decide such issues in the next case, when the insurer does not stipulate to them. Mutual of Omaha didn't want to get into these messy issues if it could show that the Americans with

Disabilities Act did not apply. If the ADA is fully applicable, insurers will have to defend their AIDS caps by reference to section 501(c), and the federal courts will then find themselves regulating the health-insurance industry, which McCarran-Ferguson tells them not to do.

Section 501(c) itself specifically relates to insurance and thus is not within the scope of McCarran-Ferguson. But the interpretation that the McCarran- Ferguson Act bars is not an interpretation of 501(c); it is an interpretation of section 302(a) that injects the federal courts into the heart of the regulation of the insurance business by the states.

Of course, we can infer from section 501(c)--we have done so earlier in this opinion--and Mutual of Omaha does not deny, that section 302(a) has some application to insurance: it forbids an insurer to turn down an applicant merely because he is disabled. To that extent, as we have already suggested, we can accept (certainly for purposes of argument) that section 302(a) relates specifically to the business of insurance. But thus limited to a simple prohibition of discrimination, section 302(a) does not impair state regulation of insurance; no state wants insurance companies to refuse to insure disabled people. It is only when section 302(a) is interpreted as broadly as it must be for the plaintiffs in this case to prevail that McCarran-Ferguson's reverse preemption comes into play.

Both because section 302(a) of the Americans with Disabilities Act does not regulate the content of the products or services sold in places of public accommodation and because an interpretation of the section as regulating the content of insurance policies is barred by the McCarran-Ferguson Act, the judgment in favor of the plaintiffs must be reversed with directions to enter judgment for the defendant.

This does not, however, leave the plaintiffs remediless. If in fact the AIDS caps in the defendant's policies are not consistent with state law and sound actuarial practices (and whether they are or not, the defendant may be bound by its stipulation, though this we needn't decide), the plaintiffs can obtain all the relief to which they are entitled from the state commissioners who regulate the insurance business. Federal law is not the only source of valuable rights.

REVERSED.

TERENCE T. EVANS, *Circuit Judge*, dissenting. The Americans with Disabilities Act is a broad, sweeping, protective statute requiring the elimination of discrimination against individuals with disabilities. *See Talanda v. KFC Nat'l Management Co.*, 140 F.3d 1090 (7th Cir.), *cert. denied*, --- U.S. ----, 119 S. Ct. 164, 142 L.Ed.2d 134 (1998). Because I believe the insurance policies challenged in this case discriminate against people with AIDS in violation of the ADA, I dissent.

The majority believes we are being asked to regulate the content of insurance policies--something we should not do under the ADA. But as I see it we are not being asked to regulate content; we are being asked to decide whether an insurer can discriminate against people with AIDS, refusing to pay for them the same expenses it would pay if they did not have AIDS. The ADA assigns to courts the task of passing judgment on such conduct. And to me, the Mutual of Omaha policies at issue violate the Act.

Chief Judge Posner's opinion likens the insurance company here to a camera store forced to stock cameras specially designed for disabled persons. While I agree that the ADA would not require a store owner to alter its

inventory, I think the analogy misses the mark. The better analogy would be that of a store which lets disabled customers in the door, but then refuses to sell them anything but inferior cameras. To pick up on another analogy raised at oral argument, we are not being asked to force a restaurant to alter its menu to accommodate disabled diners; we are being asked to stop a restaurant that is offering to its nondisabled diners a menu containing a variety of entrees while offering a menu with only limited selections to its disabled patrons. Section 501(c)'s "safe harbor" would allow Mutual of Omaha to treat insureds with AIDS differently than those without AIDS if the discrimination were consistent with Illinois law or could be justified by actuarial principles or claims experience. But Mutual of Omaha conceded that its AIDS and ARC caps do not fall under the ADA's safe harbor protection.

The parties stipulated that the very same affliction (e.g., pneumonia) may be both AIDS-related and not AIDS-related and that, in such cases, coverage depends solely on whether the patient has AIDS. In my view that is more than enough to trigger an ADA violation. Chief Judge Posner reasons that, although the policies appear to discriminate solely based on an insured's HIV status, they really don't, when you consider the nature of AIDS. He suggests that the phrase "AIDS related conditions" embodies a unique set of symptoms and afflictions that would make it easy for the insurance company to determine with certainty whether an expense incurred for a particular illness is "AIDS- related" and therefore subject to the cap. His analysis--charitable to Mutual of Omaha to be sure--may very well be medically sound. But it doesn't come from the insurance policies. The policies don't even hint at what illnesses or afflictions might fall within the ARC exclusion. Nor has the medical community embraced an accepted definition for what

"conditions" are "AIDS-related." The practical effect of all this, as Mutual of Omaha concedes, is that coverage for certain expenses would be approved or denied based solely on whether the insured had AIDS. Given that the ADA is supposed to signal a "clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities," *see* 42 U.S.C. § 12101(b)(1), I would use the statute to right the wrong committed by Mutual of Omaha.

I also part company with the majority on the McCarran-Ferguson Act analysis, and I think the faultiness of its conclusion is evident in the way the issue is framed. The Chief Judge writes: "It is one thing to say that an insurance company may not refuse to deal with disabled persons; the prohibition of such refusals can probably be administered with relatively little interference with state insurance regulation.... It is another thing to require federal courts to determine whether limitations on coverage are actuarially sound and consistent with state law." Slip op. at 564. This is somewhat misleading because, as the majority acknowledges, the question of whether these caps are actuarially sound or consistent with state law has been taken out of the equation by Mutual of Omaha's concession in the parties' stipulation. Consistent with McCarran-Ferguson we can--and we should--decide exactly what the majority seemed to think is permissible: whether an insurer may refuse to deal with disabled persons on the same terms as nondisabled persons. Because any conceivable justification for the caps (under section 501(c)) is not at issue, and because an insurer cannot legally decide to pay or not pay expenses based solely on whether an insured has AIDS and is therefore disabled under the ADA, I dissent from the opinion of the court.

United States District Court
Northern District of Illinois
Eastern Division

JOHN DOE, et al. **JUDGMENT IN A CIVIL CASE**

v. Case Number: 98 C 325

MUTUAL OF OMAHA INSURANCE CO.

☐ Jury Verdict. This action came before the Court for a trial by jury. The issues have been tried and the jury rendered its verdict.

■ Decision by Court. This action came to hearing before the Court. The issues have been heard and a decision has been rendered.

IT IS HEREBY ORDERED AND ADJUDGED that judgment is entered in favor of plaintiffs on count I and in favor defendant on count II.

Michael W. Dobbins, Clerk of Court

Date: 12/1/1998 /s/_____
Jacquelyn H. Collier, Deputy Clerk

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

JOHN DOE and RICHARD SMITH,	)	
Plaintiffs,	)	**Case No. 98 C 325**
v.	)	**Judge Conlon**
MUTUAL OF OMAHA INSURANCE COMPANY,	)	**Magistrate Judge Guzman**
Defendant.	)	

FINAL JUDGMENT

Pursuant to Rule 54 of the Federal Rules of Civil Procedure, the Court hereby enters Final Judgment in favor of Plaintiffs on Count I and in favor of Defendant Mutual of Omaha Insurance Company ("Mutual") on Count II. The terms of this Final Judgment are as follows:

1. Count I of Plaintiffs' Complaint is brought under Title III of the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12181 *et seq*. The parties agree, and the Court finds, that:

(a) Mutual sold health coverage to Plaintiff John Doe effective April 1, 1997, and Doe has been insured by Mutual under the same coverage since that date. A copy of Doe's certificate is attached.

(b) Mutual sold health coverage to Plaintiff Richard Smith effective April 30, 1992, and Smith has been

insured by Mutual under the same coverage since that date. A copy of Smith's certificate is attached.

(c) The health insurance coverage sold to Plaintiffs by Mutual places limits on the amount of benefits for Acquired Immune Deficiency Syndrome ("AIDS") and for AIDS-related conditions ("ARC"); among other things, ARC includes infection with the human immunodeficiency virus ("HIV"). These limits are referred to herein as the "AIDS Caps." Plaintiffs are among many individuals insured by Mutual whose coverage contains AIDS Caps.

(d) The AIDS Cap in Plaintiff Doe's Mutual policy is $100,000. The AIDS Cap in Plaintiff Smith's Mutual policy is $25,000. Benefits are not provided for care relating to AIDS or ARC after exhaustion of the AIDS Caps. Once the AIDS Caps are reached, benefits for AIDS or ARC can never be reinstated.

(e) For expenses unrelated to AIDS or ARC, both policies allow benefits of $1 million with limited exceptions. This $1 million cap is reinstated if no further expenses are incurred within two years.

(f) Both Plaintiffs are infected with HIV and are receiving medical treatment for this condition.

(g) Mutual applies the AIDS Caps to any expense relating to AIDS or ARC (which can include, but is not limited to, all expenses related to infection with HIV including antiviral or antiretroviral drugs or therapies, prophylaxis for prevention of opportunistic infection or illness, treatment for any opportunistic infection or resulting illness, or any diagnostic testing for HIV or

AIDS). If an expense is incurred by an insured and is not related to AIDS or ARC, Mutual will cover the expense (absent another coverage exception). If the same expense related to AIDS or ARC it would be subject to the AIDS Caps. For example, Mutual will provide coverage of up to $1 million for hospitalizations and other treatment related to pneumonia unless the pneumonia presents itself as a complication of AIDS or ARC. For insureds with AIDS or ARC, these same expenses are subject to the AIDS Caps. If, for instance, Smith had already exhausted his $25,000 limit under the AIDS Cap, he would be denied coverage for AIDS- or ARC-related pneumonia treatment. An individual who is not infected with HIV and who is not diagnosed with another AIDS-related condition or AIDS and who had not reached the $1 million cap would not be denied coverage. Further, even if such an individual had exhausted his $1 million maximum, he would be entitled to a reinstatement of benefits, provided he did not incur any expenses for two consecutive calendar years.

(h) Mutual's coverage for its insureds with AIDS and ARC is less favorable than Mutual's coverage for its other insureds. Once the AIDS Caps are reached, insureds with AIDS or ARC do not receive and cannot depend upon coverage for medical needs and treatments that are afforded to other insureds paying equivalent premiums.

(i) Plaintiffs are adversely affected by the AIDS Caps. Each Plaintiff has a physical impairment that substantially limits one or more of his major life activities and is regarded by Mutual as disabled. *See also Bragdon v. Abbott*, ___U.S.___, 118 S.Ct. 2196 (1998). The impact of HIV is more fully described in the attached

unrebutted expert testimony of Richard Novak, M.D. and Plaintiffs' affidavits. Dr. Novak is a qualified expert and his testimony is credible and reliable.

(j) Plaintiffs also have been and continue to be adversely affected by the AIDS Caps because the AIDS Caps force treatment decisions now and in the future that Plaintiffs would not otherwise have to make. These include, but are not limited to, entering an experimental drug trial program, at personal health risk, to avoid reaching the AIDS Cap limit (Plaintiff Smith), choosing currently to forego certain desirable treatments and medications because of the AIDS Cap limit (Plaintiff Doe), and facing the prospect of choosing between the recognized adverse health risks of discontinuing combination therapies or the risk of reaching or exceeding the AIDS Caps limit (both Plaintiffs). The treatments Plaintiffs may need in the future are uncertain, and each faces the risk that a benefit used for necessary treatments now will result in denial of necessary treatments later, with detrimental or fatal results.

(k) For purposes of this litigation only and without preclusive or collateral estoppel effect in any other matter, Mutual has stipulated that it will not produce evidence that its AIDS Caps are consistent with sound actuarial principles, actual or reasonably anticipated experience or bona fide risk classification or produce evidence that the AIDS Caps are based on or not inconsistent with state law, and has stipulated that Mutual has not shown and cannot show that its AIDS Caps are or ever have been consistent with sound actuarial principles, actual or reasonably anticipated experience, bona fide risk classification,

or state law. Mutual will not appeal on any of these grounds.

(l) Plaintiffs have submitted substantial, credible evidence, including the attached expert testimony and qualifications of Mark J. Browne and Fred J. Hellinger and the materials relied upon by them, to establish that AIDS Caps are not consistent with sound actuarial principles, actual or reasonably anticipated experience, bona fide risk classification or state law, and that Mutual's policy and practice of providing insureds with AIDS and ARC different and less favorable coverage than other insureds is not justified. Browne and Hellinger are qualified experts. Mutual did not offer any evidence in rebuttal on these issues.

2. The parties agree that it is desirable to avoid trial by consenting to this final judgment that has been independently approved by the Court.

3. This Court rules, for the reasons stated in its April 3, 1998, Memorandum Opinion and Order (which is incorporated herein) and based on the above and attached evidence, agreements and findings, that Plaintiffs are individuals with disabilities as defined in 42 U.S.C. § 12102(2) and have established discrimination by Mutual in violation of Title III of the ADA. The Court also finds that the AIDS Caps have not been sustained under the limited exception set forth in 42 U.S.C. § 12201(c). The Court finds that there is no need for a trial, and declares that Mutual's imposition of the AIDS Caps violates the ADA. Judgment therefore is entered in Plaintiffs' favor on Count I.

4. On October 5, 1998, this Court granted Mutual's Motion for Leave to File Amended Answer to Complaint in which Mutual amended or withdrew a Defense based on 42 U.S.C. § 12201(c) and certain Affirmative Defenses. In addition, Mutual withdraws its other Affirmative Defenses based on statute of limitations, laches, assumption of risk, and failure to mitigate damages with prejudice for this case only.

5. Plaintiffs contend that the AIDS Caps violate the ADA. Mutual denies that the AIDS Caps violate the ADA.

6. The parties have stipulated that the only issues preserved by Mutual for appeal are those raised in its Motion to Dismiss, namely, (1) whether Title III of the ADA applies to the terms and conditions of health insurance coverage; (2) the application of the McCarran-Ferguson Act to the ADA; and (3) whether the AIDS Caps constitute discrimination on the basis of a disability. Based on this stipulation, Mutual is prohibited from appealing on any other ground.

7. The parties have further stipulated that, in the event that the reviewing Court, after all appeals are exhausted, disposes of this case on any basis other than a finding that Title III of the ADA is inapplicable to the terms and conditions (such as AIDS Caps) of health insurance coverage sold by Mutual to Plaintiffs, Mutual consents to entry of an order by this Court or a reviewing court (1) in this case only, entering judgment in Plaintiffs' favor on Count I and (2) requiring the permanent removal of AIDS Caps in all health insurance coverage sold by Mutual.

8. Count II of Plaintiffs' Complaint is brought under Section 364 of the Illinois Insurance Code.

9. For the reasons stated in the April 3, 1998 Memorandum and Order, judgment is entered in Mutual's favor on Count II. The Court has dismissed Count II.

10. No party objects to the entry of judgment on Count I or Count II, subject to the preservation of each party's right to appeal from this Final Judgment. This Final Judgment is not a settlement. Except as set forth herein, nothing in this Final Judgment should be deemed a waiver by a party of its objection to and right to appeal from this Final Judgment, which each party explicitly reserves. *See, e.g., INB Banking Co. v. Iron Peddlers, Inc.*, 993 F.2d 1291, 1292 (7th Cir. 1993); *Hudson v. Chicago Teachers Union*, Local 1, 922 F.2d 1306, 1312-13 (7th Cir. 1991).

11. From the date that this Final Judgment is entered, Mutual is hereby permanently enjoined from enforcing the AIDS Caps against Plaintiffs. Mutual waives any right 1) to seek a stay of this injunction pending appeal in this Court or any reviewing court; 2) to recover any expenses that may be paid to Plaintiffs that would not have been paid if the AIDS Caps were in force; and 3) to count any expenses paid for Plaintiffs during appeal against the AIDS Caps if the AIDS Caps are reinstated.

12. As the prevailing parties, Plaintiffs are awarded their reasonable attorneys' fees and costs, pursuant to Rule 54(d), including fees and costs associated with any appeals or further proceeding, should they remain prevailing parties. Notwithstanding Paragraph 6 herein, any court order regarding attorneys' fees and costs shall be appealable.

ENTERED THIS [1st] day of [December], 1998.

/s/
Honorable Suzanne B. Conlon
United States District Judge

SUBMITTED BY:

/s/
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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

JOHN DOE and RICHARD SMITH,	)	
Plaintiffs,	)	**Case No. 98 C 0325**
v.	)	**Judge Conlon**
MUTUAL OF OMAHA INSURANCE COMPANY,	)	**Magistrate Judge Guzman**
Defendant.	)	

DEDCLARATION OF RICHARD NOVAK, M.D.

I, Richard Novak, M.D. declare as follows:

1. I have been retained by the Plaintiffs in the above-captioned litigation as an expert witness on the following subjects: the nature of HIV and AIDS, the care and treatment of persons infected with HIV or diagnosed with AIDS, and the effect that these conditions have on the lives of those who have them. My curriculum vitae is attached hereto as Exhibit A.

2. The opinions I express below are based upon years of education, training, and clinical experience treating persons infected with the human immunodeficiency virus ("HIV") or diagnosed with acquired immune deficiency syndrome ("AIDS"). I have participated in the care and treatment of such persons for 12 years. Since 1989, I have been the Director of the University of Illinois-Chicago's HIV/AIDS Project. In addition to treatment of patients with HIV/AIDS, I also direct and participate in clinical studies concerning HIV infection and AIDS.

3. HIV infection is a medical impairment that profoundly affects the body's immune system and its ability to defend itself from infection by other agents of disease. In particular, HIV affects certain components of the immune system that, once compromised, make the body vulnerable to secondary (or "opportunistic") infections. The secondary infections frequently lead to extreme sickness, and sometimes lead to death. AIDS is the late stage of illness triggered by infection with HIV. A person receives an AIDS diagnosis when he or she has a CD4 (helper T-cell) count of less than 200 and/or certain opportunistic infections that are common with advanced immune deficiency.

4. HIV infection profoundly alters the lives of those who are infected. All persons infected with HIV must contend with the knowledge that they have an infectious condition that is almost certain to shorten their lives and which is one of the most feared diseases in our society. In my experience, patients often react to the news that they are infected with HIV with profound feelings of shock, disbelief, depression and fear. Patients frequently express deep concern about the consequences of other people finding out about their HIV infection, including fears about loss of employment, insurance coverage, or support from family and loved ones. All patients must contend with critical decisions about sexual behavior, reproductive choices, their medical care and life planning. From its onset, HIV infection requires consistent monitoring and medical care to prevent, as far as practicable, the onset of opportunistic infections through the use of prophylactic medication. Most persons with HIV infection also take antiviral medications in complicated regimens to suppress HIV, which often result in debilitating side effects and require substantial changes in each patient's diet and eating habits. Ongoing medical care, and the need for strict adherence to dosing regimens for certain medications, often disrupt patients'

ability to engage in usual, daily life activities such as school or work. These and other challenges facing persons with HIV infection touch every major area of life activity.

5. HIV infection is best treated through early medical intervention to prevent the progression of immune deficiency. In addition to constant medical monitoring and prophylaxis to prevent the onset of opportunistic infection, there are well-established treatment regimens/protocols that, at least to date, are proving effective in controlling disease progression for many persons infected with HIV. Those treatments, known as "combination therapies," involve the use of several drugs that inhibit the growth of HIV infection in the body and deter or reverse the immune deficiency caused by the virus.

6. Combination therapies, while not effective in all cases, frequently are cited as being the "optimal" or "recommended" treatment regimen by medical authorities, including public health authorities. For example, guidelines published by the National Institutes of Health for the treatment of HIV infection dictate early initiation of combination therapies, including antiretroviral therapies and related care to reduce the levels of HIV in the body. This treatment can delay the progression of the disease, and can reduce the likelihood of secondary infections. Both plaintiffs are being treated through combination therapies.

7. Once a person infected by HIV has begun to receive combination therapies, it is imperative that he/she remain on such combination therapies for as long as they are effective. Even a short interruption in treatment can lead to the development of a drug-resistant strain of the virus. Once this occurs, the result is an irreversible loss of efficacy for some or all of the drugs of the type that the person had been taking.

8. As HIV leads to a deterioration of the immune system, patients usually experience a wide range of related health problems such as night sweats, chronic diarrhea, fever, weight loss, fatigue, and more frequent or severe skin or oral lesions. Opportunistic infections, such as pneumonia, encephalitis, and B-cell lymphoma may begin to appear. Patients may also experience mental slowing and involuntary weight loss, or "wasting," that ultimately may lead to death. These conditions require constant monitoring and treatment, which often is painful and invasive and may require hospitalization.

9. I have not charged any fee for my testimony in this matter.

10. I declare under penalty of perjury that the foregoing is true and correct.

Date: [11/20/98] /s/
Richard Novak, M.D.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

JOHN DOE and RICHARD SMITH,	)	
Plaintiffs,	)	**Civil Action No. 98 C 0325**
v.	)	**Judge Conlon**
MUTUAL OF OMAHA INSURANCE COMPANY,	)	**Magistrate Judge Guzman**
Defendant.	)	

DECLARATION OF JOHN DOE

1. I am the plaintiff known as "John Doe" in the above-captioned matter. I have provided a signed original of this declaration under my true name to Heather Sawyer, one of my attorneys in this case, to be filed under seal.

2. I have been self-employed since 1988. For approximately seven years, from 1990 to March, 1997, I had health insurance with Principal Mutual Insurance Company ("Principal"). In April, 1997 I obtained insurance from Mutual of Omaha as part of a special offer it made to prior Principal insureds.

3. I am infected with the human immunodeficiency virus ("HIV"). I tested positive for HIV in 1993. Within a few years, my T-cell count had dropped significantly and I was diagnosed with acquired immune deficiency syndrome ("AIDS"). I was constantly fatigued and had painful swelling

in my lymph nodes. Despite efforts to keep my weight up, I lost more than twenty pounds and suffered from nausea and diarrhea caused by the medication that I was taking. I was hospitalized because of an allergic reaction I had to my medication and was often sick. I struggled with fear and depression, knowing that I had an incurable virus that was almost certain to shorten my life.

4. My health has improved since I started taking a new combination of medication and, because my T-cell count has risen above 200, I no longer have a clinical diagnosis of AIDS. However, in order to maintain this improvement, I must take a complicated combination of drugs every day. Each morning, between 7 and 8 a.m., I take a protease inhibitor called Crixivan, and two other drugs, Zerit and 3TC, without food. Between 3 and 4 p.m. each day, I again take Crixivan, without food. Each evening, between 7 and 8 pm., I again take Zerit and 3TC, with or without food. Finally, between 11 p.m. and 12 midnight, I take another dose of Crixivan, without food. Crixivan must be taken 1 hour before a meal, or 2 hours after a meal, and with 1½ quarts of water a day. In order to comply with the dosing regimen, I have changed my eating, sleeping and work schedules. While I used to eat whenever I got hungry, or decide at the last minute to go out for a meal with friends, I now plan my meal schedule carefully to make sure I do not eat within two hours of my medication. I am often unable to sleep through the night because of the side effects of the drugs (diarrhea and frequent urination).

5. These drugs have severe side effects — I have been hospitalized because of kidney stones resulting from one drug, have frequent diarrhea, and suffer from painful swelling in my joints and other parts of my body (*i.e.*, neuropathy). Because of the recurrence of kidney stones, I am careful to drink water throughout the day. I have missed work because of

kidney stones, diarrhea, and swelling of my joints. I am always careful not to work during the hotter parts of the day because of the risk of dehydration. I also have suffered from skin dryness resulting in rashes and bleeding. Other side effects of these drugs have included increased stomach acid, resulting in acid reflux that sometimes causes sleeping problems and regurgitation, and vomiting after meals. My ongoing medical needs often disrupt my daily life and I now have to work much harder to care for my physical needs.

6. In addition, knowing that I have HIV also has had a profound effect on my long-term outlook and the way I interact with others. I have decided against adopting children. I also have decided against additional long-term investments because I am afraid that I will need that money in the short term, to care for myself and enjoy my life.

7. I am constantly aware that I have a condition that can be transmitted to others through certain kinds of intimate sexual activity and of the need to take precautions to prevent this. I also know that many people still avoid those of us with HIV due to their fears and misinformation about possible transmission and that people often lose the love and support of their friends and families, their jobs, or their insurance when it becomes known that they are infected with HIV. Because of this I remain deeply concerned that my family, friends, or work associates will find out about my HIV status. I therefore have kept this information extremely private. For example, while I have told my partner of my HIV status, my parents do not know my HIV status, my brothers do not know my HIV status, none of my other friends or relatives knows my HIV status, none of my past employers knows my HIV status, and none of my present personal or business acquaintances knows my HIV status.

8. I believe that my relationships with my family and friends would suffer or end, and that my business, and therefore my economic security, would be gravely threatened if my HIV status were known. When I told my parents that I am gay they cut off all contact with me, withdrawing all emotional support and refusing to interact with me for several years. They also withdrew all financial support and, because I was in school at the time and dependent upon them, I had to drop out of school to work. My parents and I have been able to reconcile in the past few years only because of my brother's active intervention. Because of this prior experience, I have been afraid to disclose my HIV status to my family, for I believe that my family will again cut off contact with me and that our relationship will suffer irreparable damage.

9. I run my own real estate business and own and manage residential properties in Chicago. My ability to do business depends on the goodwill I have built up with my tenants, suppliers, contractors, creditors, and lenders. I am particularly concerned that if lenders learn of my status, they will no longer do business with me, or will do it on less favorable terms.

10. Because of my concerns about others finding out my HIV status, I have been very careful about my behavior when I am around others. I also watch the clock so that I can find a way to leave before it is time for me to take my medication to avoid any questions about why I am taking medication. I hide my medications when people will be visiting my home. The need to remain secretive about my medical condition is stressful and tiring.

11. In addition to all of these changes and concerns, the limitation that Mutual of Omaha places on benefits for care relating to my infection with HIV has caused me significant

and additional stress and anxiety. I worry that I will reach my lifetime maximum and be unable to continue with the medications that, so far, have improved my health. To avoid reaching my lifetime maximum I have taken steps to decrease my medical costs.

12. For example, rather than obtaining individualized treatment from my private physician, I enrolled in a clinical drug trial experimenting with 3TC, because I could receive medication for free. I have requested viral load tests only when absolutely necessary, asked for the cheapest alternatives on my medications, and decreased the number of times I visit my doctor. I also have foregone recommended antiviral fluid tests in order to avoid additional medical costs. I would not have done any of these things if Mutual of Omaha did not limit the lifetime maximum benefits it provides for care relating to HIV or AIDS to a portion it would otherwise provide.

13. So that I can make informed choices about my medical care, I have asked Mutual of Omaha to tell me exactly what expenses will be counted against my lifetime maximum. Mutual of Omaha has told me that I must submit my claims before they will advise me of their determination. This additional uncertainty has added to my stress and anxiety. I face the prospect of choosing between the recognized adverse health risks of discontinuing my current treatment or the risk of reaching or exceeding Mutual's lifetime maximum for care relating to my infection with HIV.

14. Collectively, the psychological and physical affects of HIV and the treatments I take for HIV have had a profound, negative impact on my life, imposing substantial limitations on many major life activities and pervading the choices I make in every aspect of my daily life, from eating and

sleeping to how I think about my life and interact with my family, friends and business associates.

15. I declare under penalty of perjury that the foregoing is true and correct.

Dated: November [30], 1998

/s/
John Doe

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

JOHN DOE and RICHARD SMITH,	)	
Plaintiffs,	)	**Civil Action No. 98 C 0325**
v.	)	**Judge Conlon**
MUTUAL OF OMAHA INSURANCE COMPANY,	)	**Magistrate Judge Guzman**
Defendant.	)	

DECLARATION OF RICHARD SMITH

1. I am the plaintiff known as "Richard Smith" in this case. I have submitted a signed original of this declaration under my true name to Heather Sawyer, one of my attorneys, to be filed under seal.

2. I am self-employed and first obtained health insurance from Mutual of Omaha in April, 1992. I have been insured by Mutual of Omaha since that time. I tested positive for human immunodeficiency virus ("HIV") in November, 1996, four and one-half years after obtaining this insurance.

3. Learning that I was infected with HIV changed my life dramatically. Prior to testing positive for infection with HIV in 1996, I spent little, if any, time contemplating my own mortality. I was working hard on the business I had started a few years earlier, confident that, as my work became known, it would continue to grow. Suddenly, I had to struggle with the

knowledge that I might not have the time to do many of the things I planned for my life, such as growing old with my family and friends and building up my business. I was afraid and depressed. I worried about how I was going to care for myself and whether I would suffer from opportunistic illnesses or side effects of medications that would keep me from daily activities. I still struggle with these fears every day.

4. I also have deep fears about other people finding out my HIV status. My business and its success depends upon my reputation, goodwill, and the relationships I develop with my subcontractors and customers. I am well aware that people remain uninformed about HIV and fear interacting with people who are HIV-positive. I worry that, if it becomes known that I have HIV, I will lose subcontractors and customers.

5. I also worry that disclosure of my HIV status might damage or destroy my relationships with family and friends. My mother has had serious health problems over the past fifteen years. I have not told my mother that I am HIV-positive because this information would cause her tremendous anxiety and stress and might further damage her health. And, while I hope that other family members and friends would continue to love and support me, I am aware that valued relationships have been damaged or destroyed by disclosure of one's HIV status and am afraid that this will happen to me. Because of this, I have disclosed my status to my sister, some friends, my health care providers, my attorneys and the other plaintiff in this case.

6. In addition to the impact of HIV on my family and social relationships, I struggle with the knowledge that I have a condition that can be transmitted to others through certain kinds of intimate, sexual contact and have had to take precautions against this.

7. I have had to work much harder to care for myself on a daily basis since testing positive. I currently take three pharmaceutical drugs (Crixivan, AZT, and 3TC) for my infection with HIV. These drugs inhibit viral replication and reduce the amount of virus in the body. To be effective, they must be taken as scheduled each day. This medication schedule, and the side effects of these drugs, have required me to change what and when I eat, and to alter my sleep, work and social schedules. For example, I must take Crixivan at 7:00 a.m., 3:00 p.m., and 11:00 p.m. each day and AZT and 3TC at 11:00 a.m. and 11:00 p.m. I cannot eat at least two hours before or one hour after taking Crixivan. Therefore, to keep to the required schedule, I must now get up earlier than I used to for my first dose of Crixivan. I can no longer be spontaneous about what and when I eat meals but, instead, must plan my meal schedule carefully. I cannot eat at all during large blocks of time (before 8:00 a.m., between 1:00 and 4:00 p.m., and between 9:00 and 12:00 p.m.), and also cannot eat certain foods, such as grapefruit, that I used to enjoy.

8. These medications also have serious side effects that further limit my daily activities and threaten my health in the longer term. I have chronic diarrhea and am sometimes unable to work, socialize or otherwise keep to a previously planned schedule because of this. The drugs increase the level of triglycerides in my blood, which places me at greater risk of heart complications, and for which I must take another daily medication. The drugs similarly increase my blood sugar level, which places me at higher risk for diabetes. The AZT results in dangerously low neutrophil counts, which makes my body more susceptible to infection.

9. I also have had respiratory problems because HIV, and the medication for it, make my immune system more susceptible to such problems. While I previously had no

respiratory problems, I have developed severe breathing problems, and now I often require an inhaler. My breathing problems have caused me to miss work and take breaks from my work.

10. Before testing positive, I went to the doctor infrequently, or if I was sick or injured. I now see a physician monthly and undergo a battery of laboratory tests to check on the amount of virus in my blood and how I am responding to medications for HIV and triglycerides. I worry about my ability to pay for this ongoing care because of Mutual of Omaha's limitation on benefits relating to HIV or acquired immune deficiency syndrome ("AIDS").

11. Because I am afraid that I will reach Mutual of Omaha's lifetime maximum on benefits for my care relating to infection with HIV, and perhaps do so at a time when my health further prevents me from caring for myself or earning money to pay for my medical care, I have avoided making any claims to Mutual. To accomplish this, I have entered into clinical drug trials so that I can get medications for free. In the first drug trial that I entered, I received three doses of Crixivan a day. I also received AZT and 3TC. At the completion of this first experimental drug trial, which lasted approximately seventeen months, I entered another drug trial to determine if lower doses of Crixivan (twice daily rather than three times) were effective in suppressing viral load. I was part of the group that was required to reduce my dosing of Crixivan to twice daily. After a short time, it became clear that trial participants who had been moved to two doses were experiencing an increase in their viral loads. I was immediately moved back to three doses of Crixivan a day. I would not have taken this risk except to avoid incurring costs against my lifetime maximum with Mutual of Omaha.

12. Once they determined that Crixivan doses twice daily was ineffective, the study was canceled. As of December 22, 1998, I will have to pay for the continuation of my treatment. Among other things, I am aware that if I stop treatments, I increase the risk of creating a drug-resistant strain of HIV and that the medications will no longer be effective. My anxieties and fears about my continued ability to obtain medical care have increased with the reality that I soon will have to submit expenses that Mutual of Omaha will count against my $25,000 lifetime maximum. I face the prospect of choosing between the recognized adverse health risks of discontinuing my current treatment or the risk of reaching or exceeding Mutual's lifetime maximum for care relating to my infection with HIV.

13. Collectively, the physical and psychological consequences of my infection with HIV and the treatments for it have had major impact on my daily life, imposing substantial limitations on many major life activities. Being infected with HIV pervades how I care for myself on a daily basis, from eating to sleeping to medical concerns, as well as how I interact with family, friends, and business associates.

14. I declare under penalty of perjury that the foregoing is true and correct.

Date: November [30], 1998.

/s/
Richard Smith

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

JOHN DOE and RICHARD SMITH,	)	
Plaintiffs,	)	**Civil Action No. 98 C 0325**
v.	)	**Judge Conlon**
MUTUAL OF OMAHA INSURANCE COMPANY,	)	**Magistrate Judge Guzman**
Defendant.	)	

DECLARATION OF MARK J. BROWNE

I, Mark J. Browne, declare as follows:

1. I have been retained by the Plaintiffs in the above-captioned litigation as an expert witness to evaluate whether Mutual of Omaha's AIDS Caps are or ever have been based on sound actuarial principles, actual or reasonably anticipated experience, or bona fide risk classification. My curriculum vitae is attached hereto as Exhibit A. In addition to those qualifications stated in my curriculum vitae, I teach a course at the University of Wisconsin - Madison in Health Insurance. I am educated in and have experience relevant to the fields of underwriting and risk management in the area of health insurance.

2. As the basis for my opinions set forth below, I have relied upon my training and experience, and on documents produced by Mutual of Omaha in connection with this

litigation. In particular, I have relied upon documents relating to: the certificates of insurance issued to the plaintiffs; the submissions to the states of Illinois and Alaska relating to such certificates; Mutual's claims and other experience relating to HIV/AIDS; Mutual's internal meetings and evaluations concerning insuring the risk presented by HIV/AIDS; materials received by Mutual from outside sources, including the Health Insurance Association of America (HIAA) and professional and business publications, relating to insurance and HIV/AIDS; and other documents produced by Mutual as part of its discovery obligations. I also have reviewed other information presented by Mutual in this case, including statements concerning Mutual's HIV/AIDS experience set forth in briefs submitted by Mutual to the Court. I further have reviewed Mutual's Interrogatory responses, responses to Requests to Admit, and document request responses.

3. In addition, I have reviewed industry and other publications concerning the practice of capping or excluding benefits for care relating to HIV/AIDS, some of which also relate to quantification of the cost of care for HIV/AIDS. I also have reviewed a 1996 report on the cost of caring for HIV/AIDS relative to other medical conditions that was submitted in a case entitled *Carparts Distribution Center, Inc. v. Automotive Wholesaler's Ass'n of New England, Inc.*

4. Mutual's practice of capping benefits for care relating to AIDS/ARC (as those terms are used in the plaintiffs' health insurance certificates)[1] is not consistent with the

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[1]Based upon Mutual's discovery responses to date, I understand that HIV infection may or may not be consistently included within the definitions of AIDS/ARC used in Mutual's insurance certificates. I have considered AIDS/ARC to include HIV infection herein, since Mutual has acknowledged that in at

actuarial practices of Mutual as applied to other medical conditions for which no exclusion or limitation is found in the certificates.

5. Mutual of Omaha offers a wide variety of insurance products, including health insurance products, and is recognized in the industry as a leader in the insurance field. Accordingly, Mutual has demonstrated the expertise to price risks at different levels of insurance coverage for a wide variety of insurable conditions, including the cost of illness arising from AIDS/ARC.

6. Mutual also has the ability to underwrite for a wide variety of risks, including those presented by AIDS/ARC.

7. Unlike the Mutual policies at issue in this case, most health insurance policies do not contain internal limits capping coverage for disease arising from AIDS/ARC at a lower level than for other disease, nor do they exclude AIDS/ARC as an insurable condition.

8. The cost of treating AIDS/ARC is typically less than the cost of other severe conditions insured under the plaintiffs' certificates without caps on benefits. The costs of treating AIDS/ARC have been readily quantifiable, and have been quantified in published accounts, for many years.

9. Mutual performed and was aware of an analysis of its own claims data, which indicated that internal limits on coverage for disease arising from AIDS/ARC were unnecessary for the success of its insurance operations or the stability of its premium structure. Moreover, Mutual demonstrated that it was

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least some cases, expenses for HIV infection will be included within the limits of coverage for AIDS/ARC.

sufficiently able to limit its risk presented by AIDS/ARC through its underwriting practices.

10. Mutual has provided no information in discovery to suggest that its premium structure would vary significantly, or in ways that rendered Mutual uncompetitive, if it did not internally limit coverage for disease arising from AIDS/ARC.

11. The total percentage of "AIDS claims" identified by Mutual consistently has been very small, so as to present little risk (if any) to Mutual's operations or premium structure. The risk to Mutual was consistent with reported industry experience.

12. Mutual has identified no health insurance certificates other than those provided to plaintiffs in which Mutual capped or excluded benefits for disease arising from AIDS/ARC. Mutual therefore did not consider the costs associated with insurance for such disease to be so indeterminate as to require a cap in order to maintain the premium structure for those other insurance products. Mutual has identified no basis for limiting the risk associated with AIDS/ARC in connection with those certificates provided to plaintiffs, and for not limiting that risk arising from other certificates that contain no caps for AIDS/ARC.

13. I have been compensated at a rate of $245/hour for my work in this case.

14. I declare under penalty of perjury that the foregoing is true and correct.

Date: [November 1998] /s/
MARK J. BROWNE

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

JOHN DOE and RICHARD SMITH,	)	
Plaintiffs,	)	**Civil Action No. 98 C 0325**
v.	)	**Judge Conlon**
MUTUAL OF OMAHA INSURANCE COMPANY,	)	**Magistrate Judge Guzman**
Defendant.	)	

DECLARATION OF FRED J. HELLINGER

I, Fred J. Hellinger, declare as follows:

1. I have been retained by the Plaintiffs in the above-captioned litigation as an expert witness on the following subjects: the costs of treatment of persons with AIDS and HIV infection, the comparative costs of treating persons with other medical conditions, and Mutual of Omaha's knowledge of and ability to quantify these costs.

2. My curriculum vitae is attached hereto as Exhibit A. I am currently a senior economist with the Agency for Health Care Policy and Research (AHCPR) of the U.S. Department of Health and Human Services (USDHHS), and I have been continually employed by the USDHHS since 1983. At the AHCPR, I have analyzed data on the cost and utilization of services by persons with HIV/AIDS, and I have derived estimates of the cost of treating persons with HIV/AIDS. In

particular, I supervised a large government-funded study that collected detailed information from more than 1,000 persons with HIV/AIDS.

3. As the basis for my opinions, set forth below, I have relied upon my training and experience, publicly available information regarding the costs associated with care for HIV infection, AIDS, and other medical conditions (see Exhibits B and C), and upon documents produced by Mutual of Omaha in connection with this litigation. In addition to the list of the sources attached as Exhibits B and C, I have reviewed the following documents produced by Mutual: claims and other experience relating to HIV/AIDS; notes from internal meetings and evaluations concerning insuring the risk presented by HIV/AIDS; and other documents produced by Mutual as part of its discovery obligations.

4. I also have reviewed other information presented by Mutual in this case, including statements concerning Mutual's HIV/AIDS experience set forth in briefs submitted by Mutual to the Court. I further have reviewed Mutual's Interrogatory responses, responses to Requests to Admit, and document request responses.

5. Research into AIDS and HIV infection, including routes of transmission, incidence, and means and costs of treatment, has been conducted since the identification of AIDS in 1981. This research provides a large body of data from which to estimate the yearly and lifetime costs of treating HIV infection and AIDS, and to estimate the cumulative cost of treating persons with HIV/AIDS. Such estimates have been available to the public since the mid-1980s and consistently have shown that the cost of treating HIV/AIDS is similar to or less than the cost of treating other medical conditions, which may have incidence rates higher than those for HIV/AIDS.

6. A large number of studies on the cost of treating individuals with HIV/AIDS were conducted and published between 1985 and 1990. These studies showed that the lifetime cost of treating an individual with HIV/AIDS was between $40,000 and $80,000. Both the yearly and lifetime costs of treating persons with HIV/AIDS decreased between 1986 and 1990, in part because of reduced inpatient hospital stays. Studies published during this time also showed that the cumulative cost of treating persons with HIV infection constituted far less than 1 percent of national health expenditures.

7. Well before 1991, the year that Mutual of Omaha placed limitations on benefits relating to AIDS or AIDS Related Conditions (the terms used by Mutual in plaintiffs' health insurance certificates) in insurance certificates, studies regarding the incidence and treatment costs for HIV/AIDS were known, published, and readily available to the public.

8. Documents provided by Mutual of Omaha reveal that they were aware of these studies regarding the incidence trends of this disease. Numerous studies of the type, number, and/or cost of claims attributable to persons with AIDS/HIV were conducted by staff at Mutual of Omaha. For example, an August 12, 1987 memorandum from Gerald A. Mischke stated that, "In the last three years, AIDS claims have amounted to less than 1% of our major medical claim dollars (1,940,560/231,004,495)." A report dated September 17, 1992 indicated that the proportion of major medical claims attributable to HIV/AIDS had fallen from 1990 to 1991. See also January 30, 1990 memorandum from R. C. Olds, Senior Vice President and Director, Internal Operations.

9. The documents provided by Mutual of Omaha to date indicate that they possessed accurate and detailed

information about the treatment of persons with HIV/AIDS disease, and that this information was received by members of their AIDS Committee. None of this information suggested that the cost of treating persons with HIV/AIDS was unquantifiable due to a lack of information about the cause, the course, incidence, or amount of resources used to treat persons with this disease. Furthermore, none of this information suggested that the costs of treating persons with HIV/AIDS was unmanageable. For example, members of the AIDS Committee received information from several studies of the cost of treating HIV/AIDS that I authored, and the results of these studies are cited in the minutes of the AIDS Committee. There is also evidence that staff from Mutual of Omaha had corresponded directly with a health economist that had authored several articles on the cost of HIV/AIDS. (See July 8, 1986 notes from Gerald A. Mischke, Mutual Actuarial, Mutual of Omaha to Anne A. Scitovsky, Chief, Health Economics Department, Palo Alto Medical Research Foundations.)

10. At the time Mutual was considering placing limits for benefits relating to HIV/AIDS in its certificates of insurance, estimates regarding the costs of other medical conditions also were readily available. These comparative estimates demonstrate that the individual and cumulative costs of treating HIV/AIDS are similar to or less than such estimates for the treatment of conditions such as colorectal cancer, leukemia, lung cancer, and multiple sclerosis as shown in Table 1, attached as Exhibit C hereto.

11. As with any other medical condition, the treatment of HIV/AIDS has changed and advanced over time. Howevr, the estimated yearly cost of treating a person with HIV/AIDS has remained fairly constant, and even has decreased since the late 1980's.

12. There is nothing unique to HIV infection or AIDS that make it more difficult to quantify the costs associated with these conditions as compared to other medical conditions. On the contrary, and as discussed above, estimates regarding the incidence and costs associated with HIV/AIDS have been available for many years.

13. I have been paid $300/hour for my work in this case.

14. [There is no paragraph 14.]

15. I declare under penalty of perjury that the foregoing is true and correct.

Date: [11/24/98]

/s/
Fred Joseph Hellinger

EXHIBIT B

AIDS in New York State Through 1989, New York State Department of Health, Albany, New York, 1990.

AIDS in New York State Through 1994, New York State Department of Health, Albany, New York, 1995.

Andrulis, D. P., Beers, V., Bentley, J.D., and Gage, L.S., "The Provision and Financing of Medical Care for AIDS Patients in U.S. Public and Private Teaching Hospitals," Journal of the American Medical Association ("JAMA"), Vol. 258, No. 10, Sept. 11, 1987, pp. 1343-46.

Andrulis, D.P., Weslowski, V.B., and Gage, L.S., "The 1987 U.S. Hospitals AIDS Survey," JAMA, Vol. 262, No. 6, August 11, 1989, pp. 1343-46.

Arno, Peter S. et al., "Economic and Policy Implications of Early Intervention in HIV Disease," JAMA, Vo. 262, No. 11, Sept. 15, 1989, pp. 1493-99.

Brown, Martin L., "The Economic Burden of Cancer," in Cancer Prevention and Control (Greenwald, P. et al. eds. 1995), pp. 69-81.

Chen, R.T. et al., "Use of Hospitals by Patients with AIDS in San Francisco, The New England Journal of Medicine, 319 (25), 1988, pp. 1671-72.

Conviser, R., "Risk Adjustment of Capitated Rates for HIV Under Medicaid Managed Care," presentation at the AIDS Managed Care Conference sponsored by the Health Resources and Services Administration, U.S. Department of Health and Human Services, and the Henry J. Kaiser Family

Foundation, Renaissance Harbor Hotel, Baltimore, Maryland, Nov. 17, 1997.

Delivering and Financing Health Services in Five Communities, General Accounting Office (GAO), Government Printing Office, Washington, D.C. (GAO/HRD-120), Sept. 1989, p. 12.

Direct and Indirect Costs of Diabetes in the U.S. in 1992, American Diabetes Association, 1993.

Disease-Specific Estimates of Direcdt and Indirect Costs of Illness and NIH Support: 1997 Update, National Institutes of Health, U.S. Department of Health and Human Services, Bethesda, Maryland, September 1997.

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EXHIBIT C

TABLE 1

Disease/Condition	Year	Cost per Patient Per Year	Total Annual Cost
AIDS	1989	$32,000 (a)	$3.3 Billion (b)
Asthma	1990	--	$ 3.6 Billion (c)
Cancer (all)	1990	--	$27.5 Billion (d)
Chronic Obstructive Pulmonary Disease	1991	--	$16.5 Billion (e)
Colorectal Cancer	1990	$27,000 (f)	$6.5 Billion (g)
Leukemia	1990	$32,000 (f)	$13.2 Billion (g)
Lung Cancer	1990	$26,000 (f)	$5.1 Billion (g)
Multiple Sclerosis	1991	$10,000 (g)	$2.5 Billion (g)

(a) - Hellinger, Fred J., "Forecasting the Medical Care Costs of the HIV Epidemic: 1991-1994," Inquiry, Vol. 28, Fall 1991, pp. 213-25.

(b) - Hellinger, Fred J., "Updated Forecasts of the Costs of Medical Care for Persons with AIDS, 1989-93," Public Health Reports, Vol. 105, No. 1, Jan - Feb, 1990, pp. 1-12.

(c) - Weiss, K.B. et al., "An Economic Evaluation of Asthma

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(d) - Brown, Martin L., "The Economic Burden of Cancer," in Cancer Prevention and Control (Greenwald, P. et al. eds.), 1995, pp. 69-81.

(e) - Morbidity and Mortality Chartbook on Cardiovascular, Lung, and Blood Diseases, National Heart, Lung, and Blood Institute, National Institutes of Health, Bethesda, Maryland, May 1994.

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(g) - Disease-Specific Estimates of Direct and Indirect Costs of Illness and NIH Support: 1997 Update, National Institutes of Health, U.S. Department of Health and Human Services, Bethesda, Maryland, September 1997.

In addition, in 1990 the cost of surgery alone for each of the 284,000 persons with coronary heart disease that underwent coronary bypass surgery was $30,000 per patient; the cost of a hip fracture was about $40,000 per patient; the cost of care for drug-affected babies was about $63,000 per baby per year; the cost of treating each of the estimated 125,000 epileptics was $24,000 per patient per year. (Disease-Specific Estimates of Direct and Indirect Costs of Illness and NIH Support: 1997 Update, National Institutes of Health, U.S. Department of Health and Human Services, Bethesda, Maryland, September 1997; "Vital Statistics: What Medical Procedures Cost," The Washington Post, Feb. 16, 1993, Health Section, p. 5.)

JOHN DOE and RICHARD SMITH, Plaintiffs,

v.

MUTUAL OF OMAHA INSURANCE COMPANY, Defendant.

No. 98 C 0325.

United States District Court,
N.D. Illinois,
Eastern Division.

April 3, 1998.

MEMORANDUM OPINION AND ORDER

CONLON, *District Judge*.

John Doe ("Doe") and Richard Smith ("Smith") ("plaintiffs") bring a two count complaint against Mutual of Omaha Insurance Company ("Mutual").[1] The claims arise from plaintiffs' purchase of individual health insurance policies from Mutual. Count I alleges disability discrimination in violation of the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12101 et seq. Count II alleges a violation of Section 364 of the Illinois Insurance Code ("IIC"), 215 ILCS 5/364. Mutual moves to dismiss the complaint pursuant to Fed.R.Civ.P. 12(b)(6). Plaintiffs filed

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[1]In order to protect plaintiffs' privacy, the court granted leave to proceed anonymously under the fictitious names "John Doe" and "Richard Smith." See Order, No. 98 C 0325 (N.D.Ill. Feb.19, 1998).

a timely response. The Department of Justice ("DOJ") also filed a response brief for the United States as *amicus curiae*.

BACKGROUND

For purposes of a motion to dismiss, the court accepts all well-pleaded allegations in the complaint as true and draws all reasonable inferences in favor of the plaintiff. *Travel All Over The World, Inc. v. Kingdom of Saudi Arabia*, 73 F.3d 1423, 1429 (7th Cir.1996). Plaintiffs are Chicago residents infected with the human immunodeficiency virus ("HIV"). Mutual is a Nebraska corporation with its principal place of business in Omaha, Nebraska. Mutual offers and sells its insurance directly to members of the public at various office locations.

Both Doe and Smith hold Mutual health insurance policies that place significant limits on the amount of benefits available to individuals suffering from Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Conditions (ARC) ("AIDS/ARC caps"). Doe's policy limits recoverable benefits to a lifetime maximum of $100,000. Smith's policy limits recoverable benefits to a lifetime maximum of $25,000. By contrast, each policy provides benefits for other medical care up to a lifetime maximum of $1,000,000. In addition, for medical conditions other than AIDS and ARC, Mutual will reinstate the million dollar maximum benefit and pay additional claims on the policy after the limit is reached, provided the insured does not incur any expenses for two consecutive calendar years.

Plaintiffs allege a number of ways the AIDS/ARC caps impact their ability to obtain continued medical care. According to medical guidelines published by the National Institutes of Health, HIV infection is best treated through

early medical intervention, including antiretroviral therapies and related care aimed at reducing the levels of HIV in the body. Because Mutual considers expenses related to any treatment or care for HIV infection as part of the insured's lifetime maximum benefit for AIDS or ARC, the benefits caps adversely affect plaintiffs' ability to obtain the recommended medical care, including the initiation and continuation of antiretroviral therapies and related treatment. In particular, the AIDS/ARC caps place plaintiffs at substantial risk of exhausting their coverage in the near future. Once plaintiffs have reached the policy limits, they will be left without insurance benefits for all medical treatment related to AIDS or ARC. Thus, the policy caps not only impair the plaintiffs' ability to make treatment decisions, but pose the risk of jeopardizing plaintiffs' health by forcing an untimely interruption in medical treatment.

In Count I, plaintiffs allege that Mutual's policy caps on AIDS and ARC benefits violate the ADA's prohibition against discrimination on the basis of a disability because they deny plaintiffs the opportunity to participate in and benefit from the $1,000,000 lifetime maximum and potential reinstatement of benefits provided to insureds with other medical conditions. Count II alleges a violation of Section 364 of the IIC based on Mutual's inability to support its coverage distinctions with reference to sound actuarial principles and actual experience. 215 ILCS 5/364. Mutual moves to dismiss the complaint pursuant to Fed.R.Civ.P. 12(b)(6).

DISCUSSION

I. Motion to Dismiss Standards

In ruling on a motion to dismiss, the court considers

"whether relief is possible under any set of facts that could be established consistent with the allegations." *Bartholet v. Reishauer A.G.*, 953 F.2d 1073, 1078 (7th Cir.1992) (citing *Conley v. Gibson*, 355 U.S. 41, 45-46, 78 S. Ct. 99, 2 L.Ed.2d 80 (1957)). A claim may be dismissed only if it is beyond doubt that under no set of facts would a plaintiff's allegations entitle him to relief. *Travel All Over The World, Inc.*, 73 F.3d at 1429 (7th Cir.1996); *Venture Associates Corp. v. Zenith Data Systems Corp.*, 987 F.2d 429, 432 (7th Cir.1993) (citing *Beam v. IPCO Corp.*, 838 F.2d 242, 244 (7th Cir.1988)). The purpose of a motion to dismiss is to test the sufficiency of the complaint, not to decide its merits. *Gibson v. City of Chicago*, 910 F.2d 1510, 1520 (7th Cir.1990).

II. Scope of Title III of the ADA

This case presents a novel threshold issue of statutory interpretation under Title III of the ADA.[2] The issue is whether Title III's prohibition against unlawful discrimination extends to the content of insurance policies offered directly through an insurer. Title III's general anti-discrimination provision is found in § 302(a) of the ADA. 42 U.S.C. § 12182(a). The provision reads:

No individual shall be discriminated against based on

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[2]For purposes of this motion, Mutual assumes asymptomatic HIV positive status constitutes a disability as defined by the ADA. Mutual notes, however, that appellate courts are divided on this issue. *Compare Runnebaum v. Nations Bank of Maryland*, 123 F.3d 156 (4th Cir.1997) with *Abbott v. Bragdon*, 107 F.3d 934 (1st Cir.1997), *cert. granted*, --- U.S. ----, 118 S. Ct. 554, 139 L.Ed.2d 396 (1997). This issue is therefore not properly before the court.

> the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.

42 U.S.C. § 12182(a).[3] In Mutual's view, the plain language of this provision dictates that Title III regulates only access to goods and services offered by places of public accommodation, as opposed to the content of the goods and services themselves. According to Mutual's interpretation, since plaintiffs indisputably enjoyed equal access to the same health insurance policies available to any other individual (disabled or non-disabled) their ADA claim fails as a matter of law.

Plaintiffs offer an alternative interpretation of the plain language of § 302(a) of the ADA and of the intended scope of Title III. Plaintiffs assert that Mutual's restrictive reading of the statutory text would render meaningless § 302(a)'s requirement that persons with disabilities be accorded "full and equal enjoyment" of facilities, goods, services, privileges, or advantages of public accommodations. Limiting the reach of § 302(a) to denials of access, as Mutual suggests, misreads the text because one can only enjoy something after gaining access. Plaintiffs find additional support for this broad interpretation of Title III in the text of § 302(b). The subsection states, in relevant part:

> It shall be discriminatory to afford an individual or class of individuals, on the basis of a disability or disabilities

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[3]"Insurance offices" are included in Title III's list of "private entities that are considered public accommodations." 42 U.S.C. § 12181(7)(F).

> of such individual or class ... with the opportunity to participate in or benefit from a good, service, facility, privilege or advantage, or accommodation that is not equal to that afforded to other individuals.

42 U.S.C. § 12182(b)(1)(A)(ii). In plaintiffs' view, the text of this subsection confirms that Title III of the ADA is concerned with more than just equal access. Instead, Title III of the ADA reaches the discriminatory denial of an opportunity to benefit from or enjoy equally the goods and services of a public accommodation.[4]

Mutual relies on *Parker v. Metropolitan Life Ins. Co.*, 121 F.3d 1006 (6th Cir.1997) (en banc), *cert. denied*, --- U.S. ----, 118 S. Ct. 871, 139 L.Ed.2d 768 (1998) and *Leonard F. v. Israel Discount Bank of New York*, 967 F. Supp. 802 (S.D.N.Y.1997) as authority for its narrow interpretation of Title III's scope. In *Parker*, an *en banc* panel of the Sixth Circuit addressed whether Title III of the ADA prohibits an employer from providing a long term disability plan that distinguishes between mental and physical disorders in the amount of available benefits. The long term disability plan was challenged as discriminatory because it provided substantially lesser benefits to individuals suffering from mental disabilities, than it did to individuals suffering from physical disabilities. The Sixth Circuit held that "the provision of a long- term disability plan by an employer and administered by an employer and administered by an insurance company does not fall within the purview of Title III [of the ADA]." 121 F.3d at 1014. In arriving at this holding, the Sixth Circuit stated "[t]he applicable regulations clearly set forth that Title III regulates the availability of the

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[4]The DOJ shares plaintiffs' interpretation of the reach of Title III.

goods and services the place of public accommodation offers as opposed to the contents of the goods and services offered by the public accommodation." *Id.* at 1012. Mutual argues this language supports its restrictive reading of Title III's statutory scope.

The district court in *Leonard F.* addressed a nearly identical ADA challenge to that addressed in *Parker*. Plaintiff argued that the two year limitation for mental disorders provided by his employer's disability insurance plan was discriminatory. The first section of the court's opinion concluded that plaintiff could not state a discrimination claim against his employer under Title III of the ADA. In reaching this conclusion, the court disapproved of plaintiff's argument, in reliance on the First Circuit's decision in *Carparts Distribution Center v. Automotive Wholesaler's Ass'n of New England*, 37 F.3d 12, 17-18 (1st Cir.1994), that Title III applies to "more than mere places, in the sense of physical structures." *Id.* at 804. The district court rejected the First Circuit's ruling because "[this] decision, which is not binding precedent in this Court, is essentially dictum which flies in the face of the plain meaning of Title III and is not supported by the legislative history." *Id.* Mutual asserts the above-quoted language supports its argument that Title III does not cover the content of insurance policies.

In contrast, plaintiffs find support for their broader interpretation of the scope of Title III in *Chabner v. United of Omaha Life Ins. Co.*, 994 F. Supp. 1185 (N.D.Cal.1998) and *World Ins. Co. v. Branch*, 966 F. Supp. 1203 (N.D.Ga.1997). In *Chabner*, a plaintiff who suffered from physical disabilities sued an insurer under various state statutes and Title III of the ADA. Plaintiff alleged discrimination under the ADA because the cost of his whole life insurance policy was nearly double the rate charged to non-disabled

individuals during the same period of time. At the outset of its opinion on the insurer's motion for summary judgment, the court directly addressed whether Title III applies to insurance underwriting practices. The insurer argued that the scope of Title III of the ADA covers only discrimination in the physical access to goods and services. The court rejected this argument and held that the plain language of Title III and relevant legislative history supported its application to insurance underwriting practices. 994 F. Supp. at 1188-93. Otherwise, the court reasoned, Title III's prohibitions providing for equal access to goods and services, 42 U.S.C. § 12182(b)(1)(A)(ii), and requiring "reasonable modifications in policies, practices or procedures ... necessary to afford such goods, services, facilities, privileges, advantages or accommodations to individuals with disabilities" would be rendered superfluous, 42 U.S.C. § 12182(b)(1)(A)(ii). *Id.* at 1190.

The district court in *World Insurance Company* addressed the applicability of Title III to an insurance policy provision, like the Mutual policies at issue here, that caps lifetime coverage for AIDS treatment. 966 F. Supp. at 1207. The court first surveyed district court cases applying Title III to the content of insurance policies in related contexts. The court then examined the legislative history of the ADA. Finally, the court concluded that Title III applied to the insurer's decision to limit the maximum benefit for AIDS related treatment to $5,000. *Id.* at 1208-09.

This court finds the *Parker* and *Leonard F.* courts' limitation on the scope of Article III neither controlling nor persuasive. Contrary to Mutual's suggestion, limitation of Title III's scope to the question of discriminatory access is at odds with the plain language of Title III, relevant legislative history and the Department of Justice's interpretative

guidance. As an initial matter, the plain language of Title III's anti-discrimination provisions nowhere indicates that Title III's scope is limited to questions of access. Indeed, in order to arrive at the restrictive interpretation of Title III that Mutual advances, the *Parker* court relied on the language of the ADA regulations. The *Parker* court did not comment on the statutory text. The plain language of 42 U.S.C. § 12182(a), (b)(1)(A)(i), (b)(1)(A)(ii) and (b)(1)(A)(iii) belies the *Parker* court's narrow conclusion. Title III is patently concerned with more than just access to the goods and services offered by places of public accommodation. Rather, the plain language of Title III manifests a Congressional intent to ensure "full and equal enjoyment" of the goods and services themselves and an equal opportunity to "participate in or benefit from" goods or services offered by a place of public accommodation. 42 U.S.C. § 12182(a), (b)(1)(A)(ii); *see Doukas v. Metropolitan Life Ins. Co.*, 950 F. Supp. 422, 426 (D.N.H.1996) ("The broad wording and diversity of [§ 12182's] 'specific prohibitions,' are a strong indication that Title III was intended to extend beyond mere access or availability of a good or service.").

Applying these provisions, Mutual's insurance policy is plainly one of the "goods, services, ... privileges [or] advantages" offered by an insurance office. *See Doukas*, 950 F. Supp. at 426. It follows that, Mutual's policy caps for AIDS and ARC could plausibly constitute discrimination under any one of Title III's specific prohibitions. The AIDS/ARC caps could alternately be viewed as a discriminatory denial of the "full and equal enjoyment" of goods or a service; as a discriminatory denial of an equal opportunity to benefit from goods or a service; as the discriminatory denial of an opportunity to benefit from goods or a service; or as the provision of goods or a service different from that provided to others. § 12182(a), (b)(1)(A)(i),

(b)(1)(A)(ii), (b)(1)(A)(iii). To limit the scope of Title III to denials of access would effectively render the statutory language meaningless. *See Chabner*, 994 F. Supp. at 1190. Thus, to give full effect to Title III's plain language, it must be deemed applicable to the content of insurance policies.

The legislative history of the ADA also confirms the applicability of Title III to the substance of insurance policies. In particular, the text of both House and Senate reports acknowledges the applicability of the ADA's anti-discrimination provisions to insurance policies. For example, one House report states, in pertinent part:

> [W]hile a plan which limits certain kinds of coverage based on classification of risk would be allowed under [Section 501(c)], the plan may not refuse to insure, or refuse to continue to insure, or limit the amount, extent, or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of a physical or mental impairment, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

H.R. Rep. No. 101-485, pt. 2, at 136-37 (1990), *reprinted in* 1990 U.S.C.C.A.N. 267, 419-20. Similarly, the Senate report stated:

> virtually all states prohibit unfair discrimination among persons of the same class and equal expectation of life. The [ADA] adopts this prohibition of discrimination. Under the [ADA], a person with a disability cannot be denied insurance or be subject to different terms or conditions of insurance based on disability alone, if the disability does not pose increased risks.

S. Rep. No. 101-116 at 84 (1989). Thus, the legislative history illustrates that Congress contemplated application of the ADA to insurance policies.[5]

Finally, the DOJ's interpretative guidance provides persuasive support for the conclusion that Title III applies to the content of insurance policies. The DOJ's interpretations of Title III are expressed in both the regulations and the technical assistance manual.[6] For example, the DOJ has concluded that the ADA "reach[es] insurance practices by prohibiting differential treatment of individuals with disabilities in insurance offered by public accommodations unless the differences are justified." 28 C.F.R. ch.1, pt. 36, App. B at 619 (1996). Similarly, the DOJ's technical assistance manual states:

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[5]Other district courts have relied on similar sections of the ADA's legislative history to support the application of Title III to insurance policies. *See, e.g., Chabner*, at 1190; *World Insurance*, 966 F. Supp. at 1208.

[6]Congress has delegated to the DOJ the authority to promulgate binding regulations, 42 U.S.C. § 12186(b), and to issue a technical assistance manual providing guidance about the ADA's requirements, 42 U.S.C. § 12206(c)(3). In view of this express delegation of authority, the DOJ's regulations must be given "legislative and hence controlling weight, unless they are arbitrary, capricious, or clearly contrary to the statute." *United States v. Morton*, 467 U.S. 822, 834, 104 S. Ct. 2769, 81 L.Ed.2d 680 (1984). The technical assistance manual is entitled to similar deference. *See, e.g., Innovative Health Sys. v. City of White Plains*, 117 F.3d 37, 45 n. 8 (2d Cir.1997).

> Insurance offices are places of public accommodation and, as such, may not discriminate on the basis of disability in the sale of insurance contracts or in the terms or conditions of the insurance contracts they offer.

Title III Technical Assistance Manual § III-3.11000 (Nov.1993). Thus, the DOJ has consistently interpreted Title III as applicable to insurance policies.

In summary, Title III of the ADA applies to the content of Mutual's insurance policies. In reaching this conclusion, this court joins a growing number of district courts across the nation that have found Title III's scope to encompass review of the substance of insurance policies. *See, e.g., Chabner*, 994 F. Supp. at 1190; *Lewis v. Aetna Life Ins. Co.*, 982 F. Supp. 1158, 1163-65 (E.D.Va.1997); *World Insurance Co.*, 966 F. Supp. at 1207-08; *Cloutier v. Prudential Ins. Co.*, 964 F. Supp. 299, 301-02 (N.D.Cal.1997); *Doukas*, 950 F. Supp. at 425-26; *Kotev v. First Colony Life Ins. Co.*, 927 F. Supp. 1316, 1321-22 (C.D.Cal.1996); *Anderson v. Gus Mayer Boston Store of Delaware*, 924 F. Supp. 763, 779 (E.D.Tex.1996); *Baker v. Hartford Life Ins. Co.*, No. 94 C 4416, 1995 WL 573430, *3 (N.D.Ill. Sept.28, 1995). The contrary conclusion Mutual urges would undermine the plain language of Title III, and disregards legislative history as well as the compelling guidance of the DOJ.

III. Title IV of the ADA

Mutual next points to § 501(c) of Title IV of the ADA as proof of Congress' intent to curtail the reach of Title III to insurance policies. Section 501(c) provides, in relevant part:

> Subchapters I through III of this chapter and Title IV of

this Act shall not be construed to prohibit or restrict--

> (1) an insurer ... from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law;
>
> ....
>
> Paragraph[ ](1) ... shall not be used as a subterfuge to evade the purposes of subchapter I and III of this chapter.

42 U.S.C. § 12201. Mutual contends § 501(c) establishes a rule of construction. According to Mutual, § 501(c) exhibits Congress' intent to prohibit any construction of Article III that would impose an affirmative obligation on insurance companies to design policies in a certain way. By contrast, plaintiffs argue the inclusion of § 501(c) only reinforces the conclusion that Title III reaches the content of insurance policies.

Plaintiffs' view of § 501(c) is in line with the predominant weight of authority. Section 501(c) has been commonly construed as a form of "safe harbor" provision for insurance companies. *See, e.g., Modderno v. King*, 82 F.3d 1059, 1063-64 (D.C. Cir.1996); *Chabner*, at 1190; *Lewis*, 982 F. Supp. at 1165-1166; *World Insurance Co.*, 966 F. Supp. at 1207-08; *Kotev*, 927 F. Supp. at 1322. Under this safe harbor, the challenged underwriting practice or risk classification does not violate the ADA if it accords with "sound actuarial principles, reasonably anticipated experience, or bona fide risk classification," or does not otherwise constitute a "subterfuge to evade the purposes of the ADA." *World Insurance Co.*, 966 F. Supp. at 1208, 1209 n. 6. Rather than signaling Congress' intent to broadly exempt insurance companies from the reach of Title III of the ADA, § 501(c)'s safe harbor provision manifests the contrary intent to subject insurance companies to the full scope of the ADA's anti-

discrimination prohibitions. *See Chabner*, at 1190 ("If Title III were meant only to prevent insurance companies from denying persons with disabilities equal access to the physical plants of insurance offices, there would have been no need for Congress to include the safe harbor provision dealing with underwriting practices."); *see also Kotev*, 927 F. Supp. at 1322 (insurers would not need "this 'safe harbor' provision ... if insurers could never be liable under Title III for conduct such as the discriminatory denial of insurance coverage"). Mutual may later avail itself of § 501(c)'s safe harbor by demonstrating the caps placed on AIDS and ARC in plaintiffs' policies were consistent with sound actuarial principles, reasonably anticipated experience, or bona fide risk classification. However, § 501(c) does not support Mutual's argument that Title III of the ADA does not reach the content of insurance policies.

IV. The McCarran-Ferguson Act

Mutual next argues that a straightforward application of the McCarran-Ferguson Act, 15 U.S.C. § 1012 et seq., precludes application of the ADA to insurance policy content. The McCarran-Ferguson Act provides, in relevant part, that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance ... unless such Act specifically relates to the business of insurance." 15 U.S.C. § 1012(b). Under McCarran-Ferguson, unless a federal statute clearly provides otherwise, it must be construed as inapplicable to the business of insurance. *See, e.g., U.S. Dept. of Treasury v. Fabe*, 508 U.S. 491, 507, 113 S. Ct. 2202, 124 L.Ed.2d 449 (1993); *Barnett Bank of Marion County, N.A. v. Nelson*, 517 U.S. 25, 116 S. Ct. 1103, 1113, 134 L.Ed.2d 237 (1996). In essence, Mutual argues that Title III of the ADA does not satisfy this clear statement test. In

particular, Mutual asserts that the only mention of insurance in Title III is the reference to "insurance office" in 42 U.S.C. § 12181(7). Mutual contends this minor reference does not exhibit the necessary intent to regulate the content of insurance policies, business or practices.

In response, plaintiffs and the DOJ argue that McCarran-Ferguson does not preclude application of Title III to the content of insurance policies. Mutual fails to demonstrate McCarran-Ferguson bars application of Title III to the content of its insurance policies for the two independent reasons pressed by plaintiffs and the DOJ. First, § 501(c) expressly provides that insurance underwriting practices shall not be used to evade the purposes of Title III. In this manner, the ADA "specifically relates to the business of insurance" for purposes of the McCarran-Ferguson Act. § 1012(b); *see Barnett Bank*, 116 S. Ct. at 1111-1113. In arguing to the contrary, Mutual limits its clear statement inquiry to the language of Title III. The question is whether the ADA as a whole contains sufficient specific references to the insurance industry, not whether a specific title within the ADA contains such references. Taking into account both the reference to "insurance office" in Title III and the language of § 501(c) in Title IV, the ADA contains sufficiently specific indicia of an intent to apply its prohibitions to the insurance underwriting practices.

Second, Mutual has not identified any state law that an application of Title III of the ADA would "invalidate, impair, or supersede." § 1012(b). Indeed, as plaintiffs note, Illinois insurance law consistently forbids Mutual's alleged discriminatory practice:

> No company, in any policy of accident or health insurance issued in this State, shall make or permit any

> distinction or discrimination against individuals solely because of handicaps or disabilities ... in the amount of any dividends or other benefits payable thereon, *or in any other terms and conditions of the contract it makes, except where the distinction or discrimination is based on sound actuarial principles or is related to actual or reasonably anticipated experience.*

215 ILCS 5/364 (West 1997) (emphasis added). Where there is no conflict between the federal statute and state law, as in this case, the McCarran-Ferguson Act does not bar application of federal law. *See, e.g., Nationwide Mut. Ins. Co. v. Cisneros*, 52 F.3d 1351, 1363 (6th Cir.1995), *cert. denied*, 516 U.S. 1140, 116 S. Ct. 973, 133 L.Ed.2d 893 (1996); *Merchants Home Delivery Serv. Inc. v. Frank B. Hall & Co.*, 50 F.3d 1486, 1491-93 (9th Cir.), *cert. denied*, 516 U.S. 964, 116 S. Ct. 418, 133 L.Ed.2d 335 (1995); *NAACP v. American Family Mut. Ins. Co.*, 978 F.2d 287, 295-97 (7th Cir.1992). Accordingly, application of Title III of the ADA to Mutual's policies is not precluded by the McCarran-Ferguson Act.

V. ADA Discrimination

Mutual argues that AIDS/ARC caps do not constitute discrimination against individuals "on the basis of a disability," 42 U.S.C. § 12182(a), because they are a permissible distinction in the level of benefits provided to one category of disability as differentiated from other categories. Mutual finds support for this argument in a trio of appellate decisions addressing challenges under the ADA and the Rehabilitation Act, 29 U.S.C. § 794, to employer health benefit plans or long term disability plans that provide inferior benefits for mental disabilities, as compared to physical disabilities. *See, e.g., EEOC v. CNA Ins. Cos.*, 96

F.3d 1039 (7th Cir.1996); *Modderno v. King*, 82 F.3d 1059 (D.C. Cir.1996); *Parker*, 121 F.3d 1006. These cases uniformly reject the notion that providing unequal benefits as between the broad categories of mental and physical disabilities constitutes cognizable discrimination. *EEOC*, 96 F.3d at 1044; *Modderno*, 82 F.3d at 1061; *Parker*, 121 F.3d at 1015-16. In sum, Mutual urges that because its policies similarly provided different levels of benefits for different disabilities the AIDS/ARC caps are not discriminatory under the ADA.

Mutual's attempt to make plaintiffs' claim fit the rule of *EEOC*, *Parker*, and *Modderno* fails because these cases are inapposite. Unlike the claims in each of those cases, the ADA claim in this case focus on Mutual's singling out of individuals with a particular disability, AIDS, for inferior coverage as compared to that afforded non-disabled individuals. Indeed, the *Parker* court specifically distinguished differentiation between broad categories of individuals with different disabilities from the discrimination prohibited by the ADA--discrimination between the disabled and non-disabled. 121 F.3d at 1014. Similarly, the Seventh Circuit distinguished its decision from a case where an insurer chooses "to vary the terms of its plan depending on whether the employee was disabled." *EEOC*, 96 F.3d at 1044. The alleged discrimination at issue here is well-illustrated by plaintiffs' hypothetical example. Mutual will provide coverage of up to $1 million dollar for hospitalizations related to pneumonia for non-disabled individuals. Whereas if the pneumonia presents itself as a complication of AIDs, it is deemed an aids related condition (ARC) and subject to the AIDS/ARC cap. If, for instance, Smith had already exhausted his $25,000 dollar limit for AIDS related care, he would be denied coverage for pneumonia treatment. A non-disabled individual who had

not reached the $1 million dollar cap would not be denied coverage. Further, even if that non-disabled individual had exhausted his $1 million dollar maximum, he would be entitled to a reinstatement of benefits, provided he did not incur any expenses for two consecutive calendar years. The same reinstatement benefit is not provided to disabled persons after exhaustion of the AIDS/ARC cap. This example exposes the discriminatory nature of Mutual's policies--they subject plaintiffs to altogether different terms and conditions than non-disabled individuals. In sum, plaintiffs' allegations of differential treatment on the basis of AIDS are sufficient to state a cognizable claim of discrimination in violation of Title III of the ADA.

VI. Section 364 of the Illinois Insurance Code

In Count II, plaintiffs seek to state a claim for violation of § 364 of the Illinois Insurance Code. 215 ILCS 5/364. As noted above (see part IV), § 364 provides:

> No company, in any policy of accident or health insurance issued in this State, shall make or permit any distinction or discrimination against individuals solely because of handicaps or disabilities ... in the amount of any dividends or other benefits payable thereon, or in any other terms and conditions of the contract it makes, except where the distinction or discrimination is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

215 ILCS 5/364 (West 1997) (emphasis added). Conceding that the Illinois legislature has not seen fit to provide a private remedy for violations of this section of the IIC, plaintiffs argue that this court should find an implied right of action under the statute.

Plaintiffs argue that an implied right of action should be found under the rationale expressed in *Sawyer Realty Group, Inc. v. Jarvis Corp.*, 89 Ill.2d 379, 59 Ill.Dec. 905, 432 N.E.2d 849, 854-855 (1982). In *Sawyer* the Illinois Supreme Court articulated the following elements useful to the determination whether there is an implied right of action under a state statute:

> 1. The plaintiff is a member of the class of persons for whose benefit the statute was enacted;
> 2. The plaintiff's injury is one which the statute was designed to prevent;
> 3. A private right of action is consistent with the underlying purpose of the statute; and
> 4. A private right of action is necessary to effectuate the purposes of the act.

See id. Except perhaps for the first element, none of the other *Sawyer* elements counsels in favor of finding an implied right of action. Although the IIC benefits insurance customers, its primary concern is direct regulation of the insurance industry. There is no authority for the proposition that the underlying purpose of IIC, in particular Article XX ("Accident and Health Insurance"), was to redress discrimination by insurers. Moreover, creation of an implied private cause of action under § 364 is not necessary to effectuate the statutory purposes of the IIC because it specifies remedies for the section's violation. *See Langendorf v. Travelers State Ins. Co.*, 625 F. Supp. 1103, 1106 (N.D.Ill.1985) (no need for implied private right of action under IIC because Director of Insurance empowered to issue cease and desist orders against insurer who commits proscribed acts). For example, section 5/730 provides that "any company, or any officer or agent thereof, issuing or delivering to any person in this State any policy in wilful violation of the provision of this article shall

be guilty of a petty criminal offense." 215 ILCS § 5/370(1). Further, the Director of Insurance is empowered to revoke or suspend the license of a foreign or alien company wilfully violating the article or to order payment of a monetary penalty. 215 ILCS § 5/730(2). Thus, implication of a private cause of action under § 364 is unwarranted.

In declining to recognize an implied right of action under § 364 of the IIC, the court is mindful of the fact that no Illinois court has found an implied private right of action under any provision of the Act. As courts of limited jurisdiction, federal courts are reluctant to effect dramatic expansions of state law absent indication from the state supreme court, or at the very least a clear line of state appellate court authority. *See DeMent v. Abbott Capital Corp.*, 589 F. Supp. 1378, 1387 (N.D.Ill.1984) (refusing to imply private cause of action under the Illinois Securities Act where no Illinois court had ever held that an individual could pursue private remedies under the Act). Accordingly, plaintiffs' claim pursuant to § 364 of the IIC must be dismissed.

CONCLUSION

Plaintiffs adequately state a claim that the AIDS/ARC caps in Mutual's insurance policies constitute discrimination in violation of Title III of the ADA. In contrast, plaintiffs fail to state a claim under the IIC because this court finds no implied private right of action. Accordingly, the motion to dismiss is granted in part and denied in part. Count II of the complaint is dismissed with prejudice. Defendant's motion is denied in all other respects.

ENTER:

April 3, 1998

/s/
Suzanne B. Conlon
United States District Judge

United States Court of Appeals
For the Seventh Circuit
Chicago, Illinois 60604

August 3, 1999

Before
Hon. Richard A. Posner, Chief Judge
Hon. Frank H. Easterbrook, Circuit Judge
Hon. Terence T. Evans, Circuit Judge

JOHN DOE and RICHARD SMITH,	**Appeal from the United States District Court for the Northern District of Illinois, Eastern Division.**
Plaintiffs-Appellees,	**No. 98 C 325**
No. 98-4112 v.	
	Suzanne B. Conlon, *Judge.*
MUTUAL OF OMAHA INSURANCE COMPANY,	
Defendant-Appellant.	

ORDER

On June 16, 1999, plaintiffs-appellees filed a petition for rehearing with suggestion for rehearing *en banc* and on July 13, 1999, defendant-appellant filed an answer. A vote of the active members of the Court was requested, and a majority has voted to deny a rehearing en banc.* The petition is thereby **DENIED.**

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* Hon. Joel M. Flaum, Hon. Kenneth F. Ripple, Hon. Ilana Diamond Rovner, Hon. Diane P. Wood and Hon. Terence T. Evans voted to grant the petition for rehearing en banc.

Title III of the Americans with Disabilities Act of 1990

Title 42. The Public Health and Welfare
Chapter 126. Equal Opportunity for Individuals with Disabilities
Public Accommodations and Services Operated by Private Entities

42 U.S.C. §§ 12181 et seq. (1995)

§ 12181. Definitions

As used in this title [42 U.S.C. §§ 12181 et seq.]:

* * *

(7) Public accommodation. The following private entities are considered public accommodations for purposes of this title [42 U.S.C. §§ 12181 et seq.], if the operations of such entities affect commerce —

* * *

(F) a laundromat, dry-cleaner, bank, barber shop, beauty shop, travel service, shoe repair service, funeral parlor, gas station, office of an accountant or lawyer, pharmacy, insurance office, professional office of a health care provider, hospital, or other service establishment;

* * *

§ 12182. Prohibition of Discrimination by public accommodations

(a) General rule

No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.

(b) Construction

(1) General prohibition

(A) Activities

(i) Denial of participation

It shall be discriminatory to subject an individual or class of individuals on the basis of a disability or disabilities of such individual or class, directly, or through contractual, licensing, or other arrangements, to a denial of the opportunity of the individual or class to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations of an entity.

(ii) Participation in unequal benefit

It shall be discriminatory to afford an individual or class of individuals, on the basis of a disability or disabilities of such individual or class, directly, or through contractual, licensing, or other arrangements with the opportunity to participate in or benefit from a good, service, facility, privilege, advantage, or

accommodation that is not equal to that afforded to other individuals.

(iii) Separate benefit

It shall be discriminatory to provide an individual or class of individuals, on the basis of a disability or disabilities of such individual or class, directly, or through contractual, licensing, or other arrangements with a good, service, facility, privilege, advantage, or accommodation that is different or separate from that provided to other individuals, unless such action is necessary to provide the individual or class of individuals with a good, service, facility, privilege, advantage, or accommodation, or other opportunity that is as effective as that provided to others.

(iv) Individual or class of individuals

For purposes of clauses (i) through (iii) of this subparagraph, the term "individual or class of individuals" refers to the clients or customers of the covered public accommodation that enters into the contractual, licensing or other arrangement.

(B) Integrated settings

Goods, services, facilities, privileges, advantages, and accommodations shall be afforded to an individual with a disability in the most integrated setting appropriate to the needs of the individual.

(C) Opportunity to participate

Notwithstanding the existence of separate or different programs or activities provided in accordance with this section, an individual with a disability shall not be denied the

opportunity to participate in such programs or activities that are not separate or different.

(D) Administrative methods

An individual or entity shall not, directly or through contractual or other arrangements, utilize standards or criteria or methods of administration—

(i) that have the effect of discriminating on the basis of disability; or

(ii) that perpetuate the discrimination of others who are subject to common administrative control.

(E) Association

It shall be discriminatory to exclude or otherwise deny equal goods, services, facilities, privileges, advantages, accommodations, or other opportunities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

(2) Specific prohibitions

(A) Discrimination

For purposes of subsection (a) of this section, discrimination includes—

(i) the imposition or application of eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any goods, services, facilities, privileges, advantages, or accommodations, unless such

criteria can be shown to be necessary for the provision of the goods, services, facilities, privileges, advantages, or accommodations being offered;

(ii) a failure to make reasonable modifications in policies, practices, or procedures, when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations;

(iii) a failure to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the good, service, facility, privilege, advantage, or accommodation being offered or would result in an undue burden;

(iv) a failure to remove architectural barriers, and communication barriers that are structural in nature, in existing facilities, and transportation barriers in existing vehicles and rail passenger cars used by an establishment for transporting individuals (not including barriers that can only be removed through the retrofitting of vehicles or rail passenger cars by the installation of a hydraulic or other lift), where such removal is readily achievable; and

(v) where an entity can demonstrate that the removal of a barrier under clause (iv) is not readily achievable, a failure to make such goods, services, facilities,

privileges, advantages, or accommodations available through alternative methods if such methods are readily achievable.

* * *

§ 12186. Regulations

(a) Transportation provisions.

* * *

(b) Other provisions. Not later than 1 year after the date of the enactment of the Act [enacted July 26, 1990], the Attorney General shall issue regulations in an accessible format to carry out the provisions of this title [42 U.S.C. §§ 12181 et seq.] not referred to in subsections (a) that include standards applicable to facilities and vehicles covered under section 302 [42 U.S.C. § 12182].

* * *

Title V of the Americans with Disabilities Act of 1990

Title 42. The Public Health and Welfare
Chapter 126. Equal Opportunity for Individuals with Disabilities
Miscellaneous Provisions

42 U.S.C. §§ 12201 et seq. (1995)

§ 12201. Construction

(a) In general. Except as otherwise provided in this Act, nothing in this Act shall be construed to apply a lesser

standard than the standards applied under title V of the Rehabilitation Act of 1973 (29 U.S.C. 790 et seq.) or the regulations issued by Federal agencies pursuant to such title.

* * *

(c) Insurance.

Titles I through IV of this Act shall not be construed to prohibit or restrict —

(1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(2) a person or organization covered by this Act from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(3) a person or organization covered by this Act from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of title I and III [42 U.S.C. §§ 12111 et seq., 42 U.S.C. §§ 12181 et seq.]

* * *

§ 12206. Technical assistance

* * *

(c) Implementation

(1) Rendering assistance. Each Federal agency that has responsibility under paragraph (2) for implementing this Act may render technical assistance to individuals and institutions that have rights or duties under the respective title or titles for which such agency has responsibility.

(2) Implementation of Titles.

* * *

(C) Title III. The Attorney General, in coordination with the Secretary of Transportation and the Chair of the Architectural Transportation Barriers Compliance Board, shall implement such plan for assistance for title III [42 U.S.C. §§ 12181 et seq.], except for section 304 [42 U.S.C. § 12184], the plan for assistance for which shall be implemented by the Secretary of Transportation.

* * *

(3) Technical assistance manuals. Each Federal agency that has responsibility under paragraph (2) for implementing this Act shall, as part of its implementation responsibilities, ensure the availability and provision of appropriate technical assistance manuals to individuals or entities with rights or duties under this Act no later than six months after applicable final regulations are published under titles I, II, III, and IV.

* * *

Regulations and Technical Assistance of the Department of Justice

Title 28 — Judicial Administration
Chapter 1 — Department of Justice
Part 36 — Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities
Subpart B — General Requirements

28 C.F.R. § 36.212 (1998)

§ 36.212 Insurance

(a) This part shall not be construed to prohibit or restrict-

(1) An insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(2) A person or organization covered by this part from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with Sate law; or

(3) A person or organization covered by this part from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

(b) Paragraphs (a) (1), (2), and (3) of this section shall not be used as a subterfuge to evade the purposes of the Act or

this part.

(c) A public accommodation shall not refuse to serve an individual with a disability because its insurance company conditions coverage or rates on the absence of individuals with disabilities.

Appendix B to Part 36 -- Preamble to Regulation on Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities (Published July 26, 1991)

Section 36.212 Insurance

The Department received numerous comments on proposed § 36.212. Most supported the proposed regulation but felt that it did not go far enough in protecting individuals with disabilities and persons associated with them from discrimination. Many commenters argued that language from the preamble to the proposed regulation should be included in the text of the final regulation. Other commenters argued that even that language was not strong enough, and that more stringent standards should be established. Only a few commenters argued that the Act does not apply to insurance underwriting practices or the terms of insurance contracts. These commenters cited language from the Senate committee report (S. Rep. No. 116, 101st Cong., 1st Sess., at 84-86 (1989) (hereinafter "Senate Report")), indicating that Congress did not intend to affect existing insurance practices.

The Department has decided to adopt the language of the proposed rule without change. Sections 36.212(a) and (b) restate section 501(c) of the Act, which provides that the Act shall not be construed to restrict certain insurance practices on

the part of insurance companies and employers, as long as such practices are not used to evade the purposes of the Act.

* * *

Language in the committee reports indicate that congress intended to reach insurance practices by prohibiting differential treatment of individuals with disabilities in insurance offered by public accommodations unless the differences are justified. "Under the ADA, a person with a disability cannot be denied insurance or be subject to different terms or conditions of insurance based on disability alone, if the disability does not pose increased risks" (Senate report at 84; Education and Labor report at 136). Section 501(c)(1) of the act was intended to emphasize that "insurers may continue to sell to and underwrite individuals applying for life, health, or other insurance on an individually underwritten basis, or to service such insurance products, *so long as the standards used are based on sound actuarial data and not on speculation*" (Judiciary report at 70 (emphasis added); see also Senate report at 85; Education and Labor Report at 137).

The committee reports indicate that underwriting and classification of risks must be "based on sound actuarial principles or be related to actual or reasonably anticipated experience" (see, *e.g.*, Judiciary report at 71). Moreover, "while a plan which limits certain kinds of coverage based on classification of risk would be allowed * * *, the plan may not refuse to insure, or refuse to continue to insure, or limit the amount, extent, or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of a physical or mental impairment, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience" (Senate report at 85; Education and Labor report at 136-37; Judiciary report at 71). The ADA, therefore, does

not prohibit use of legitimate actuarial considerations to justify differential treatment of individuals with disabilities in insurance.

* * *

DEPT. OF JUSTICE, TITLE III TECHNICAL ASSISTANCE MANUAL § III-3.11000 (1993)

III-3.11000 Insurance. Insurance offices are places of public accommodation and, as such, may not discriminate on the basis of disability in the sale of insurance contracts or in the terms or conditions of the insurance contracts they offer. Because of the nature of the insurance business, however, consideration of disability in the sale of insurance contracts does not always constitute "discrimination." An insurer or other public accommodation may underwrite, classify, or administer risks that are based on or not inconsistent with State law, provided that such practices are not used to evade the purposes of the ADA.

Thus, a public accommodation may offer a plan that limits certain kinds of coverage based on classification of risk, but may not refuse to insure, or refuse to continue to insure, or limit the amount, extent, or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of a physical or mental impairment, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience. The ADA, therefore, does not prohibit the use of legitimate actuarial considerations to justify differential treatment of individuals with disabilities in insurance.

* * *

The McCarran-Ferguson Act

Title 15. Commerce and Trade
Chapter 20. Regulation of Insurance

15 U.S.C. § 1012 (1997)

§ 1012. Regulation by State law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948

* * *

(b) Federal regulation. No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance.

* * *